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ABSTRACT

This conference report briefly summarizes the biological and psychosocial characteristics and problems of the age group 5 to 18 years, and defines solutions to these problems in terms of research needed, changes in health services, changes in general services, and changes in manpower training. The perceived need for such recommendations was based on two premises: (1) that the process of rapid socioeconomic development and industrialization now taking place in Europe has profoundly changed the nature of the problems experienced by children and adolescents; and (2) that existing services for children and adolescents are inadequate and/or inappropriate for solving these new problems. The characteristics and problems of children identified were based on findings of earlier working groups. Detailed reports of these groups are available elsewhere. Problems identified concern the following topics: deviations in growth and development, mortality and morbidity, chronic diseases, infectious diseases, nutrition, problems related to sexual development, psychosocial reactions to growth and development, accidents, suicide, juvenile delinquency, substance (tobacco, alcohol and drugs) abuse, school problems, work entry, and leisure-related problems. Recommendations include the need for research on the following topics: normal growth, development and behavior; morbidity and mortality; specific biological problems; and specific psychosocial problems. Other solutions discussed concern the organization of health services; health education; services for families, school, and the community; and manpower training. Lists of participants and related WHO publications are included. (Author/SS)

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The Child and the Adolescent in Society

Report on a WHO Conference

Athens
26–30 September 1978

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WHO CONFERENCE ON THE CHILD AND THE ADOLESCENT IN SOCIETY

Athens, 26 – 30 September 1978

1. INTRODUCTION

1.1 Opening session

A Conference on the Child and the Adolescent in Society was convened in Athens from 26 to 30 September 1978 by the WHO Regional Office for Europe in collaboration with the Government of Greece. The Conference was attended by representatives of 22 Member States, 10 temporary advisers, representatives of 6 nongovernmental organizations, 8 observers and 5 staff members of the WHO Regional Office for Europe and headquarters. It brought together professionals from many disciplines concerned with children and adolescents: public health planners; administrators and experts in the fields of family health, maternal and child health, and family planning; administrators of health education programmes; scientists; and teachers, researchers and service personnel in the fields of paediatrics, public health, nursing, midwifery, education psychology, sociology and architecture (for list of participants see Annex II).

The participants were welcomed by Professor S. Doxiadis, Minister of Social Services of Greece. On behalf of WHO, Dr L.A. Kaprio, Regional Director for Europe, pointed out that the Conference was the culmination of a series of activities carried out by the Regional Office. The Regional Committee for Europe, which guided the policy of the Regional Office, had felt that more emphasis should be placed on child health; he hoped, therefore, that definite guidelines would emerge from the Conference reflecting the wishes of Member States with regard to the focus and direction of WHO programmes concerning children and adolescents.

In his introductory address, Professor Doxiadis expressed the hope that the discussions would lead to action. He cautioned that more research and knowledge concerning childhood and adolescence were certainly needed, but that decisions on policy and programmes of action were required immediately and could not be postponed while new knowledge and data were being accumulated. He emphasized the vital link between education and health, and the role of professionals in the health sciences as catalysing agents in the introduction of new ideas. He urged the participants to consider the development of the child's social conscience – the "intelligence of the heart" – and keep in mind the individuality of each child by measuring the success of services for children (such as education) by changes brought about in the individual during the process.

Professor Doxiadis was elected Chairman and it was decided that he should be assisted by three Vice-Chairmen. The following were elected: Professor M. Çoruh, Dr K. Bozkowa, and Professor P. Hubinont.

Dr V. Tatočenko, temporary adviser to the Regional Office for Europe, and Dr M. Wagner, Regional Officer for Maternal and Child Health, acted as Co-Rapporteurs.

Dr Wagner, who also acted as Conference Secretary, explained that the results of the deliberations could have important implications for the training of personnel in many fields in the future. He hoped that significant changes and innovations in services for children and adolescents would result from the Conference's recommendations.

1.2 Scope and purpose

The purpose of the Conference was to recommend solutions to the problems of children and adolescents (5–18 years of age) in society today. The need for such recommendations is based on two premises: (1) the process of rapid socioeconomic development and industrialization now taking place in the Region has profoundly changed the nature of the problems experienced by children and adolescents; (2) existing services for children and adolescents are inadequate and/or inappropriate for solving these new problems.

With regard to the first premise, it is universally acknowledged that society has been radically transformed by socioeconomic development and industrialization and that this process of change is continuing. New patterns of behaviour, development, health and disease have emerged which have created new needs and new problems. Improvements in standards of living, including better housing, nutrition and sanitation, are primarily responsible for the remarkable reduction in mortality rates, but they have also led to increased concern with the quality of life. Socioeconomic development and industrialization, the application of modern technology, and advances in the treatment of certain diseases and conditions have created a social climate in which expectations and aspirations have risen in all age groups and all levels of society.

These expectations and aspirations are not only higher than in the past, but are also different and often difficult to express. Demands for more and different services which it is believed will enhance the quality of life have far-reaching implications for all services. In such demands, expression is frequently given to the vague but deeply felt desire for a normal, healthy, happy life. But what do the terms "normal" and "healthy" mean when applied to children and adolescents? And if we felt competent to define happiness, would our definition not necessarily include a consideration of health?

A general improvement in the health status of the population has invalidated the "sick/healthy" dichotomy of the medical model. It is evident

that in one way or another and at some time or another all children are subject to health deviances. The concept of "normal", then, is a convenient administrative term and what, in fact, is "normal" is the presence of health deviance or, more correctly, variance.

A second difficulty when considering normality is the potential confusion between average, normal and optimal. What is measured as the average is labelled normal and is often assumed to be optimal. If what are generally considered to be improved socioeconomic conditions are associated with a larger average size of children, then bigger children are regarded as normal and desirable. If, however, these same "improved" socioeconomic conditions are also associated with increasing average blood pressures in children as they grow, is this higher average blood pressure still to be considered normal, desirable or optimal? "Normal", then, should be restricted to the meaning "average" and should not include any connotation of "desirable" or "optimal". It is particularly important to bear this in mind because, as we shall see, many of the problems of children and adolescents today may arise to some extent from the notion, pervasive in modern industrialized society, that growth *per se* is not only necessary but desirable. This belief is reflected, for instance, in the current trends towards overnutrition (leading to obesity), overmedication, and overeducation (labelling as normal or subnormal, pressure for academic achievement).

Concern for the quality of life has also affected our understanding of abnormality in children and adolescents. Socioeconomic development and industrialization have brought chronic diseases and conditions to the forefront.

Children who are chronically sick no longer either die or "get well" again. Rather, the disease or disability is present in the body, mind and social awareness of the child over a long period of time and medical intervention is a caring and not a curing strategy. Our goal has now become the management of the illness, i.e., of the child's reaction to the disease or disability state, and not the management of the disease itself – the focus of traditional medical practice. This has led to a re-evaluation of the role of the medical sciences in problems related to health; it has resulted in a new understanding of their inherent limitations and, in some cases, unsuitablity and has made it clear that an interdisciplinary approach to problems (including "health" problems) is necessary.

Our understanding of abnormality is changing in another significant way. Medical science began with the study of pathology – the internal changes which are the causes and consequences of disease – and since that time medical science has been focused on internal physical and mental factors. Recently, however, we have become aware of the importance of all human environmental conditions – the ecosystem – in the causation, care and cure of ill health. When one begins to consider these external factors, one immediately encounters a host of new realities which include the importance of

the physical environment in health; the role of the microsocial environment (close to the individual, e.g., the family, school, local neighbourhood) and the macrosocial environment (removed from the individual, e.g., the level of industrialization and urbanization, the political structure of society) in disease causation and disease control.

The social sciences have long recognized the importance of all environmental conditions, but the relevance of the latter to illness is only now being fully appreciated once again. We have learned that, just as the environment must be considered in its totality, so must the individual, it being impossible to isolate any one aspect (such as health) from other aspects. This enlarged understanding of external factors in abnormality has led to a reappreciation of the central role of the family in the health and development of children and adolescents. But the family, like the rest of the microsocial and macrosocial environment, is in a state of rapid change and flux in industrialized societies and these changes must be taken into consideration.

In view of the changing nature of the problems of children and adolescents in industrialized society, the second premise, that present services for children are often inadequate and should be re-evaluated, is self-evident. In almost all countries of the European Region, present maternal and child health (MCH) services stem from a long-standing tradition which is based on the medical model and which still focuses on the rudimentary health needs of mothers: training in baby care, the avoidance of undernutrition, anaemia and rickets, and the control of infectious disease, thus reflecting a preoccupation with the needs and problems of a past era. The designation "maternal and child health" itself indicates that in the past these services have concentrated on the problems of infancy and early childhood and have attached relatively slight importance to the period of adolescence.

In the past, economic conditions dictated that adolescence be bypassed and replaced by early adulthood as children joined the work force at or near the age of puberty, but today adolescence has become a critical and major period of individual development and has grown in importance as far as MCH services are concerned.

The inadequacy or inappropriateness of MCH services in relation to the new problems of children and adolescents in industrialized society was clearly recognized by the WHO Conference on New Trends in Maternal and Child Health[a], which stated: "Severe shortcomings in almost all parts of the Region have been revealed by a survey of MCH services in Europe and most of them were confirmed and amplified by the discussions in the Conference. Though they are, of course, of a different nature they apply to developed and developing parts of the Region. To a large extent they must be seen as the result

[a] **WHO Regional Office for Europe.** *New trends in maternal and child health:* Report on a Conference. Copenhagen, 1975 (ICP/HRP 004).

of incongruence between the new knowledge which is bringing new dimensions to family health and the traditional views on services. This criticism was made with considerable force."

As a result of this earlier conference the WHO Regional Office for Europe organized three working groups [a,b,c] to study new problems of children and adolescents in industrialized society. After reviewing the reports of these working groups, the present Conference sought to put forward solutions which might be appropriate to these problems.

The scope of the Conference was necessarily and desirably broad, both in the geographical area it encompassed and in the breadth of the subject it was considering. While there are great differences within and between the countries of the European Region, their diversity in no way precludes important similarities between them: all countries of the Region are industrialized or rapidly approaching that state; they are all confronted with problems involving the critical period of childhood and adolescence. The Conference wished to ensure an interdisciplinary approach in the conception and formulation of solutions to the problems of children and adolescents today which would include theoretical, administrative, clinical, technical, pedagogical and practical considerations at all levels and for all services. The problems of children aged 5–18 years and all services provided for that age group in the contexts of health, education and psychosocial development were considered.

2. CHARACTERISTICS OF THE AGE GROUP 5–18 YEARS

The Conference had the advantage of being able to rely on the reports of the earlier working groups which had defined the characteristics of the age group 5–18 years in some detail. These characteristics will be summarized here and the reader who desires more information is referred to the reports of the relevant working groups.[a,b,c] A comprehensive list of related WHO publications is given in Annex I.

[a] **WHO Regional Office for Europe.** *Problems of children of school age (5–9 years)*: Report on a Working Group. Copenhagen, 1976 (ICP/MCH 004).

[b] **WHO Regional Office for Europe.** *Problems of children of school age (10–13 years)*: Report on a Working Group. Copenhagen, 1977 (ICP/MCH 006).

[c] **WHO Regional Office for Europe.** *Problems of children of school age (14–18 years)*: Report on a Working Group. Copenhagen, 1978 (ICP/MCH 010).

2.1 Population characteristics

The number of children and adolescents in this age group in Europe is shown in the following table. (The European Region of WHO is not geographically coextensive with Europe but the same general trends apply.)

Population projections (1965–1980) for the age group 5–18 years by geographical region (figures given in thousands).

Year	Europe	Western Europe	Southern Europe	Eastern Europe	Northern Europe	USSR
1965	109 506	32 938	31 495	26 797	18 277	65 484
1970	112 494	34 700	32 710	26 617	18 479	70 118
1975	115 228	36 259	33 887	25 662	19 421	67 816
1980	118 613	37 452	35 051	25 482	20 630	65 758

Source: World Health Organization. *World Health Statistics Report*: **28** (4) (1975).

In the 15 years from 1965 to 1980 there will be a total world increase of 30% in the number of children and adolescents (5–19 years of age). This will be due to population growth in this age group in the developing world, not in the more developed world. The European Region follows the general demographic trend. As can be seen in the table, southern Europe shows a substantial increase in this age group, and western and northern Europe show slight increases; eastern Europe and the USSR, on the other hand, show slight decreases in the number of children and adolescents. These differences reflect past variations in birth rates; present rates may show trends that differ considerably from those indicated above.

2.2 Biological characteristics

The Conference chose to separate the characteristics of children and adolescents into three parameters for the purposes of discussion: biological (including sexual), psychological and social, it being understood that these characteristics are integral, dynamic and interactive.

The single most important biological characteristic of children and adolescents is their vigour, strength, rapid growth and physical development. Children and adolescents are positive, "healthy" biological organisms, requiring emotional and physical outlets, expression and activity, even during acute or chronic illness. Younger children become more mobile in their own, self-defined neighbourhood as they satisfy a need to explore their expanding

environment. They learn to test the limits of their physical development by risk-taking. As they grow older their recreational needs expand and sports, whether organized formally or informally, are increasingly important to them. While the need for physical activity in children and adolescents is universal and continuous, data are unfortunately lacking on optimal levels of activity at various ages and on the consequences of too little activity (for example in chronic disease or handicap) or too much activity (for example in very young sports champions).

A second major biological characteristic of the age period 5–18 years is puberty. The onset of puberty (usually between the ages of 10 and 13) is accompanied by general physical and sexual changes. General physical changes include the growth spurt and changes in body composition. The growth spurt (acceleration of growth) usually starts with accelerated growth of fatty tissues leading to a temporary "rounding out" of body contours, followed by accelerated growth of bones producing a "lean" body shape and finally by muscular growth giving the body an "adult" shape. Changes in body composition include growth and maturation of cardiovascular, respiratory and muscular systems, leading to increased strength and efficiency of body energy production.

Sexual change is a much longer process, involving the interaction of biological, psychological and social factors (presented together at this point). The development of an individual's sexuality begins in early childhood and includes gender identity (the feeling that one is a boy or girl) and the beginning of sex roles (the behaviour appropriate to a boy or girl). With the onset of puberty the production of sex hormones results in the development of secondary sex characteristics including growth of the reproductive organs, body hair and adult male/female body configuration. These biological changes, in turn, combine with the psychosocial environment to produce a rapid increase in sexual interest and sexual behaviour.

One form of sexual interest and behaviour is that directed towards oneself. It is common for younger children to explore their own bodies and masturbate. This behaviour increases during puberty. Masturbation in childhood and adulthood is natural and healthy and should not be regarded as a form of regression unless it replaces all other forms of sexual behaviour.

Another form of sexual interest and behaviour which develops rapidly at puberty is sexual preference for an object of special interest. Typically, in early adolescence teenagers develop close relationships with individuals of the same sex; it is normal that such relationships should occasionally include explicit homosexual behaviour. The persistence of such homosexual behaviour to the exclusion of the later development of heterosexuality is poorly understood, but it is important that this phenomenon be recognized and accepted.

Puberty, in most cases, sees the rapid development of heterosexual preferences and behaviours which have biological roots but are profoundly

influenced by the values and standards of the family, community and society. Courting behaviour (social and physical interaction prior to living together) varies widely among the cultures and subcultures of the European Region but usually progresses from group social interaction involving both sexes, through social interaction involving only one couple to physical interaction between a couple. The age of debut of sexual intercourse appears to be falling: in many if not most areas of the Region the majority in both sexes have experienced sexual intercourse before their nineteenth birthday.

Among those adolescents who are sexually active, the use of contraceptives varies widely from 5% or less in some areas in the Region, to over 80% in others. Condoms and withdrawal appear to be the most common methods used by younger adolescents, while the diaphragm and oral contraceptives become more popular among older teenagers. Studies show that large numbers of sexually active adolescents use no form of contraception and that for the most part this results from ignorance of the various methods available and from a gap between theoretical knowledge and practice. Even in countries where programmes of sex education are provided in the schools, contraceptive information is given later than conception information and is not accompanied by personal guidance with regard to methods. Children and adolescents who are aware of contraceptive methods may not put this knowledge to use; they may still lack information about how contraceptives can be obtained or they may misunderstand contraceptive methods and fear to use them.

The final stage in the development of sexuality is living together and family formation. In most of the industrialized areas of the Region (and the world) the age of persons entering their first marriage is rising, at least partly because of the longer time required to complete one's education or training and the wish to postpone family formation until a career is established. Cohabitation (living together) prior to or in place of marriage is increasing in frequency in some areas of the Region. Cohabitation may enable older adolescents to complement the development of their physical sexuality by the development of their psychosocial sexuality and thus bring the two levels of development into greater concordance. This phenomenon should be recognized and understood.

An important fact regarding the biological characteristics of children and adolescents in industrialized areas is that the age of biological maturation (including sexual maturation) has dropped by about 4 months per decade during the past century. If this trend continues, in the year 2000 young people will be biologically mature one year earlier than they are today. Puberty and sexual activity at an earlier age, coupled with the later age of family formation, will extend the period of risk of pregnancy among fertile couples who do not want children. At the same time, schooling has been prolonged in many industrialized countries, further widening the gap between biological and social maturity.

The considerable variance observed in the process of growth and development must also be taken into account. There is wide variance in the age of the onset of puberty both within and between sexes. It is now recognized that variance in the age of onset of puberty is influenced by environmental factors, including social conditions, nutrition and climate, as well as by genetic factors. This variance is important, both to the professionals who must identify the normal limits of early development and late development, and to children and adolescents themselves, who must understand and accept the wide range in body size, shape and functioning to be found in their peer groups.

Growth and development are separate concepts and desynchronization of these two processes is another important variance. Furthermore, a considerable variation, in individuals, between their levels of biological maturity, psychological maturity and social maturity is a common feature and is another facet of the great variance to be observed in children and adolescents.

2.3 Psychological characteristics

Psychological development includes both cognitive and emotional development. A multitude of factors (parents, siblings, peers, teachers, employment, climate, etc.) may affect or influence personality development, but its focus is on individual behaviour and its internal determinants. In the past it has been popular to divide the psychological development of children into definitive stages, but more recently the more continuous nature of this development has been recognized. The Conference reviewed normal psychological development in broad age periods, the continuity of which should be understood.

Cognitive development in 5–9-year-olds is characterized by an open-minded eagerness to learn without yet being limited by more orthodox thinking. Learning at this age is dependent on direct experience; behaviour is in imitation of a model. Emotionally, children at this age are still quite dependent on parents and/or parent surrogates.

Between the ages of 10 and 13 years children become conscious of their own abilities. Self-awareness and concern for others increase. Adult-like reasoning skills also develop. Between the ages of 14 and 18 the development of adult abstract thinking skills is completed. The psychological transformation to adulthood, i.e., the perception of the self as an adult, takes place at this time and includes a striving for independence and the formation of an identity. The development of sexual interest and behaviour is also part of personality development; this has been considered separately above.

2.4 Social development

Social development, or socialization, is the process of learning social roles and ways of performing them, as well as acquiring and internalizing

society's values, norms of conduct, moral standards and perceptions of the surrounding world. Through socialization the child learns how to act as a member of society and how to coexist with its members. This is accomplished by its contact with the social environment, both microsocial and macrosocial (see p. 4). Socialization, like psychological development, is a continuous process, but for the purposes of discussion it will be considered here by periods of age.

Children aged 5–9 years are still socially dependent on their families, although other elements in the microsocial environment such as peers and adults in the neighbourhood begin to become important. The impact of the macrosocial environment is beginning to be felt. "Inschooling" (the process of beginning schooling) is an essential part of socialization during this period.

The family, school, community and peers all play important roles in the process of socialization during the period 10–13 years, but family ties begin to loosen and peer relationships assume greater importance.

In young people aged 14–18 years the influence of schools as socializing agents nears termination or ends and is usually replaced by a job setting. Conflicts between the family and the adolescent often occur at this time, especially in industrialized society. Peer group acceptance increases in importance. Local and distant heroes are admired and emulated. The influence of the macrosocial environment becomes dominant and crucial, especially as it affects job and career opportunities and the selection and recognition of the options available in adult life. During the teenage years the self emerges as a determinant of social behaviour, and is manifested by independence of thought and action. (The sexual development discussed earlier is, of course, an integral part of socialization and a major influence on social interaction during adolescence.)

In preindustrial society the process of socialization was easily and clearly definable and the transition from adolescence to adulthood was taken for granted. But profound changes in modern industrial society have disrupted the process; the entry of teenagers into adult society has become haphazard and hazardous. No well-marked paths exist from adolescence to adulthood in a society which is itself in a state of flux. For this reason, the social development of children and adolescents today is of critical importance.

It is clear that the psychological and social aspects of development overlap. When, for example, a mother and child interact, both the psychological and the social development of the child and its mother are affected. As a consequence, the two processes are often considered together. Psychosocial development, then, includes cognitive, emotional and social development. Everything affects the psychosocial development of children and adolescents, including biological development (and its deviations), the psychological history of the child and its present personality, and the past and present microsocial and macrosocial environments. The predominant role of psychosocial development will become apparent from the next section.

3. PROBLEMS OF THE AGE GROUP 5–18 YEARS

The Conference followed the dictum that the definition of a problem determines its solution. The reports of the three earlier working groups on problems of children of school age (see p. 5) were reviewed and their findings concerning the nature and priorities of the problems of children in this age group were fully endorsed. This report will briefly review the problems previously identified, leaving a fuller description to the earlier reports.

The Conference recognized the inherent danger of having problems defined by the professionals who control their solutions. Children and adolescents are, in the main, robust and "healthy", and yet health professionals in particular are accustomed to thinking in terms of disease. As stated earlier, health deviance is the rule, not the exception, but most instances of deviance (or problems) threaten the quality of life, not the quantity of life. The impact of deviance on the daily lives of children and adolescents cannot be determined or measured by professional observers, but must be determined by the individual himself and by his close associates. Thus, for example, health professionals emphasize the importance of cancer as a major killer in children and adolescents, and yet for every case of cancer there must be many thousands of cases of severe acne which significantly affect the daily psychosocial adjustment of adolescents. Definitions of the problems of children and adolescents must focus at all times on health rather than on disease and on the overall impact of any "problem" on the quality of the lives of the entire population of children and adolescents.

Industrial development in the European Region has profoundly changed the nature of the problems of children of school age. Improvements in the general socioeconomic level, improved environmental health (water, sanitation, etc.) and advances in health services and medical sciences, in that order, have reduced or eliminated some of the old problems such as poverty, illiteracy, infectious disease and undernutrition. At the same time, industrialization and changes in society have produced or created conditions which favour the emergence of new problems. The characteristics of these new problems are to a great extent unknown, although there is clearly a shift away from acute physical diseases towards chronic diseases and conditions and psychosocial problems (dominant in industrialized areas) for which the classical medical model is often unsuited. The distribution and severity of the new problems vary according to economic, social, cultural, historical, psychological and industrial factors and any evaluation must include consideration of all of them.

For the purposes of discussion, the problems of children and adolescents were divided into biological and psychosocial categories, it being understood that biological and psychosocial factors would overlap and interact, given the nature of the human organism.

3.1 Biological problems

3.1.1 *Deviations in growth and development.*

Two questions must be asked with regard to growth and development in children and adolescents: how are deviations perceived by professionals, and how are deviations perceived by children and adolescents and by their associates? By failing to recognize the importance of environmental influences on growth and development, professionals have inappropriately applied growth and sexual maturation standards which are based on data from other geographical areas or are outdated, and have assumed that these "normal" standards represent optimal development. Such standards focus on anatomical development (height, weight, skin thickness, etc.) and do not include measurements of functional development (physical fitness, dyskinesia, etc.). Such standards are usually limited to biological development and do not include intellectual, emotional, and social development, for which comparable and reliable standards are lacking. The importance of measuring all of these parameters of development simultaneously in the individual in order to determine the degree of asynchronization among them and establish a developmental profile is not yet sufficiently appreciated.

Because children and adolescents have not been informed about the wide variance in normal growth and development (between individuals, and between parameters in one individual, over time) they perceive such variance as abnormal. This frequently leads to inappropriate psychosocial reactions in individuals which can profoundly influence their further psychosocial development. Little is known about the psychosocial consequences of developmental variance.

3.1.2 *Mortality and morbidity*

Mortality rates for children of school age (5–18 years) show a tendency to converge at a threshold of approximately 40 deaths a year per 100 000 – the lowest rate of any period of life. In parts of the Region where the death rate is significantly higher, such as in southern Europe, mortality rates have fallen sharply in recent years. This has been attributed to a decrease in the incidence of infectious diseases. In countries where the rate has already reached this threshold, such as in northern Europe, there have not been further decreases since the major residual causes of mortality – tumours and violent death (accidents, suicide) – have remained at the same levels. In several fully industrialized countries mortality rates have risen as a result of increases in the number of violent deaths. This suggests that "overdevelopment" is accompanied by rising death rates, even among children. The higher mortality rate in boys begins at birth and increases throughout childhood until, by adolescence, the male death rate is twice the female death rate.

Though the mortality rate among children and adolescents is low, morbidity rates, which are clearly more important indicators of health status, are not well known. Data on morbidity are meagre, inadequate and biased. Available data come from medical treatment institutions such as hospitals and present only the narrow, disease-oriented aspects of morbidity. The prevalence of the much more common non-life-threatening physical conditions (such as acne) and psychosocial conditions has never been investigated.

3.1.3 *Chronic diseases*

Chronic diseases in children and adolescents in industrialized society are increasingly important for a number of reasons. The reduction in the prevalence and severity of acute diseases has resulted in a relative and proportionate increase in the prevalence of chronic diseases. Industrialization is associated with certain phenomena (air pollution, food additives, overmedication) which may increase the absolute frequency of certain chronic diseases such as cancer, allergy and chronic respiratory disease. Success in the treatment of certain diseases (malignant diseases, diabetes, etc.) increases survival rates, leading both to greater numbers of surviving but affected individuals and to a prolongation of the lives of survivors. The psychosocial consequences of chronic disease in this context are apparent and the quality of life of chronically diseased persons becomes an issue. Finally, the adaptation of chronically ill children and adolescents to their environment is rendered more difficult by the complexity and demands of modern society.

Chronic diseases and disabilities affecting children and adolescents include a wide range of conditions, stable to progressive, continuously active to episodic, diffuse to specific, socially benign to stigmatic. They encompass dramatic and severely disabling diseases such as cerebral palsy and the less visible conditions of diabetes and allergies. Milder conditions are often overlooked, yet they are much more prevalent and produce special problems which will be discussed below.

The reaction of the affected individual and of society to the chronic condition becomes a key issue. Chronic diseases and disabilities are not inherently handicapping: handicaps are the product of society's and the individual's perception of a disorder or disability. Motivation, capability and opportunity may interfere with or reverse the handicapping process. The negative aspects of handicap are magnified by ignorance, unfamiliarity, fear and stereotype ideas. There is often a tendency to focus on the abnormal characteristics of the affected individual rather than on his predominant normal characteristics.

The reaction of the individual to his own chronic condition is itself frequently a problem. Childhood and adolescence are periods of rapidly increasing self-awareness, particularly with regard to the body, and the young

person with a chronic disease is especially prone to develop a distorted or confused image of himself.

The family's reaction to a chronically ill child may also present problems. For a variety of reasons, which often include the family's awareness of the stress experienced by a disabled person in adapting to society, it is common for the family to try to reduce stress by adapting the home environment to the chronically ill child. While this may temporarily reduce stress, it has the disadvantage of creating an artificial world around the child in which he cannot test or experience reality.

The effects of schools on chronically ill or disabled children and adolescents are crucial. The predominant reaction of schools to date has been to focus on the abnormal characteristics of such children and in so doing to categorize or label them and separate them from "normal" students. This is unfortunate, both for the "abnormal" student, whose more dominant and more important normality is underemphasized, and for the "normal" student, who is denied contact with those showing serious and chronic health variance, for it undermines society's understanding of the normality of deviance in the human group. In addition, the education of chronically ill students has been less than ideal: our understanding of the complex interaction between health variance and learning is, at best, sketchy and incomplete.

Unfortunately, medical care of the chronically ill or disabled child has also been most often characterized by exaggerated emphasis on any abnormality, to the neglect of the child's normality and overall welfare and development. This is evident in such widespread practices as: hospitalization by disease category; unnecessarily prolonged hospitalization; unnecessary hospitalization when outpatient care would suffice; lack of psychosocial and educational services in hospitals; lack of development of alternatives to conventional hospitalization (day wards, weekday wards, etc.); lack of development of family support services; and failure to encourage and expand the role of the child and family in the management of the condition.

3.1.4 *Infectious diseases*

As we become more successful in combating infectious diseases in more developed areas, our knowledge of their residual problems decreases and our commitment to continue combating them sometimes falters. Our knowledge of the "old" infectious diseases (or of infectious diseases in developing areas) is now irrelevant because these diseases are dynamic entities: the infectious agents change, the characteristics of the host change, the characteristics of the disease process change and the epidemiology of the disease changes. At the same time, immunization programmes present problems in the more developed areas for several reasons: as yet there is no effective immunization against the most common infectious diseases in these areas; provider and/or

consumer resistance to immunization programmes can result in pockets of unimmunized or underimmunized children and the recrudescence of a disease (e.g. poliomyelitis); inadequate information on the duration of effectiveness and the dangers of immunization (for example in pertussis) can produce overimmunized children or unnecessary iatrogenic complications and sequelae. Our knowledge of specific risk groups in industrialized areas, such as children at school entry, children of migrant families and young drug abusers, is also insufficient.

3.1.5 *Nutrition*

In this day and age it is perhaps surprising that very little is known about the level of nutrition, nutritional risk groups and nutritional problems of children and adolescents in an industrialized society. Because food and eating are so strongly influenced by such psychosocial factors as social and religious customs, personal habits and child-rearing patterns, the field of nutrition is filled with inconsistencies, misunderstandings and myths and this confusion is aggravated by the fact that most nutritional scientific work has been concentrated on the more severe forms of undernutrition, followed by a tendency to inappropriately apply such data to the more developed areas. An increasingly important but again poorly understood issue is the long-term effect of nutrition in childhood on subsequent growth and development, adult dietary habits, and the development in adult life of chronic diseases such as cardiovascular disease.

Nutritional risk is an important concept and it has been well known for some time that nutrition is critical during periods of rapid growth and development. While the prenatal and infant periods have been the focus of nutritional study, adolescence has been surprisingly neglected as another period of rapid growth and development. In fact, the basic nutritional requirements of adolescents have not yet been clearly established, though they must be different from those of children or adults because of the growth spurt, sexual development, increased physical exercise, increased metabolic rate and emotional stress. Because nutritional risk is associated with many factors (economic, social, cultural, emotional, industrial, geographical) it must necessarily vary from country to country and within countries and must be determined locally.

Industrialization and social change have created three new nutritional problems affecting children and adolescents: overnutrition, convenience foods and collective feeding. Overnutrition, especially obesity, is more and more becoming a matter of concern in developed areas, both because of its increasing prevalence and because of the growing recognition that its roots lie in early childhood and its consequences extend into adulthood and old age. Psychosocial factors are important in both the etiology and the consequences of obesity.

The traditional family meal is becoming less important in the dietary patterns of children and adolescents. While an increasing amount of processed food and "convenience" foods (pre-cooked, premixed, etc.) is consumed, the quality of these foods varies and the nutritional value to young people is in many cases unknown. Collective feeding is also increasing; in many European countries a collective meals service is now provided by schools. While such services are often under the direction of competent nutritionists, too often the relationship between the school meal and the rest of the food consumed that day is not considered and there is no involvement of the child, teacher, family or community in the selection and preparation of school meals.

3.1.6 *Problems related to sexual development*

Problems which may occur as a result of sexual development include unwanted pregnancy, unwanted childbirth, induced abortion and sexually transmitted diseases. These problems received considerable attention at the Conference, but since they are discussed in some detail in the report on the Working Group on Problems of Children of School Age (14–18 years) (see p. 5), only a brief review will be presented here.

The onset of puberty and sexual activity at an earlier age without a simultaneous increase in the use of effective contraception has resulted in a near-epidemic increase in the rate of adolescent pregnancy in the European Region. The Conference stressed that this phenomenon cannot be defined as a "problem" unless the pregnancy is unwanted; however, since marriages in most areas are taking place at a later age, most adolescent pregnancies will be unwanted.

The growing number of adolescent pregnancies, without a simultaneous increase in the rates of induced abortion in adolescents, has resulted in a rapid increase in the number of births to teenage women in most countries of the Region. Since childbirth under 17 years of age is associated with increased risk to both mother and child and since the psychosocial consequences (early school leaving, premature forced marriage, etc.) are also considerable, these younger teenage births, at least, can be defined as a "problem".

Although data are available only sporadically, they suggest a more recent increase in rates of induced abortion among adolescents. The younger the teenager, the higher the rate of induced abortions per pregnancy tends to be (the opposite is the case with childbirth). The consequences, both physical and psychosocial, of induced abortion are unclear; earlier research suggested increased risk, but more recent and better controlled studies refute this finding. The Conference agreed that since induced abortion represents intervention rather than the primary prevention of pregnancy, emphasis should be on contraception rather than abortion. At the same time, in most cases abortion is preferable to childbirth for a teenage woman with an unwanted

pregnancy since the choice is between the consequences of abortion and those of an unwanted pregnancy, unwanted childbirth and, most important, an unwanted child.

Adolescent fertility, as reflected in rates of pregnancy, childbirth and abortion, varies considerably from country to country but appears, in general, to follow a defined pattern of events, beginning with increased levels of sexual activity followed by larger numbers of pregnancies, then by larger numbers of births, then by an increase in the rate of induced abortions, and lastly by increased utilization of contraceptives.[a] These trends have important prognostic implications for individual countries wishing to develop preventive services.

Since sexually transmitted diseases may be assumed to be unwanted, they can certainly be defined as a problem, particularly since the dramatic increase in the incidence of these diseases among adolescents is well documented. This marked recrudescence is rooted in a complex interaction of socioeconomic, psychosocial and biological factors, but appears to be definitely related to increasing industrial development in general. The prevention and treatment of sexually transmitted diseases is especially difficult in teenagers because of their ignorance or misconceptions concerning these diseases and their hesitation or fear to seek medical advice from traditional medical sources. While it has been assumed that a high degree of promiscuity among sexually active young people has also contributed to this problem, recent studies suggest that this promiscuity is more fiction than fact.

3.2 Psychosocial problems

3.2.1 *General*

While biological problems may have psychosocial consequences and psychosocial problems may have biological consequences, the separation of problems into these two categories is more than a matter of convenience, since solutions should be aimed, insofar as is possible, at prevention and this requires a search for primary etiologies. Psychosocial problems, then, have a basic etiology which is psychosocial, that is, they are inappropriate psychosocial reactions of the individual to something (or things) in the environment. Psychosocial problems may have some internal cause; for instance, the individual may react inappropriately to the rapid physical, sexual and psychological changes of childhood and adolescence; or they may be the result of external factors, e.g., features of the microsocial or macrosocial environment. Whatever the factors involved, they have in common a tendency to

[a] For further details see report on the Working Group on Problems of Children of School Age (14 – 18 years) (ICP/MCH 010).

produce stress in the individual in the face of increasing insecurity, alienation and anomy.

The microsocial factors involved in the etiology of psychosocial problems often include the family. Many of the stabilizing forces of more traditional family life have been eroded. Family instability increases the risk of stress and inappropriate psychosocial reactions. The school, as will be seen, is also frequently a factor in the etiology of these problems.

Macrosocial factors which have been found to be frequently associated with increased risk of psychosocial problems include urbanization and non-optimal socioeconomic conditions. Increasing urbanization is a phenomenon common to all areas of the European Region. Some of the deleterious effects of urbanization (crowding, etc.) are familiar to everyone, but its pervasive effects on children and adolescents go far beyond these. Urbanization for them implies: detachment from natural processes and resources; less opportunity to explore the environment; the imposition of too many rules restricting conduct; an environment that is on too big a scale for children; little or no possibility of restructuring the surroundings.

For a number of reasons, socioeconomically deprived children and adolescents are at higher risk of falling victim to psychosocial problems. The families of such children are more often forced to migrate, and more likely to be disrupted or broken than the average family. Children and adolescents living in suboptimal social and economic conditions are less well prepared for school, more likely never to attend school, more likely to leave school early, and more likely to be labelled by the school as mentally retarded. Furthermore, the socioeconomically deprived are always the most vulnerable in general to the demographic, economic and political upheavals of our time.

In most children and adolescents with psychosocial problems the predisposing environmental factors are multiple. While this often makes it difficult to establish etiologies precisely in individual cases, it does make it possible to identify individuals or groups most likely to encounter psychosocial problems.

Psychosocial problems, then, are reactions of the individual to environmental stresses. Because of the rapid communications that exist in modern society, the environmental factors involved are more or less common to the whole European Region. The way in which children or adolescents react, however, is influenced by local conditions and varies considerably from country to country and within countries. In general, nevertheless, three categories of reaction are frequently encountered. The first is a passive form of coping which includes varying degrees of withdrawal, ranging from school-leaving to "dropping out" of society in general and to its most extreme form – suicide. The second is an aggressive form of coping which includes juvenile delinquency, gang violence and its most extreme form – terrorism. The third category includes some compromise reaction, such as instability at school or work and substance abuse.

In addition to considering the nature of the individual's reaction, it is also essential to consider the reaction of society to the reactive behaviour of the individual. If the individual's reaction includes behaviour which is in conflict with the social norms and expectations of a particular group or society and which lies outside the range of socially acceptable nonconformity to these roles, then the reaction is termed social deviance (delinquency, drug abuse, etc.). It is well to remember, however, that there are psychosocial reactions which do not fall outside the limits of socially acceptable nonconformity but which still exist as psychosocial problems. Thus, a cigarette-smoking teenager has a problem but an adolescent alcoholic is a social deviant.

Since psychosocial problems are social, not medical, in nature, their evaluation and management should obviously not be limited to the medical approach. Rather than "diagnosing" the psychosocial "symptoms", it is usually more worthwhile to view the individual as being in a certain environmental situation and therefore having special needs. It is also important not to blame the victim, i.e., to label him or her "bad", but rather to understand that the reaction is an inappropriate and usually self-defeating attempt to cope. The existence of psychosocial problems should be a reminder to all community institutions – schools, churches, clinics and hospitals, neighbourhood organizations, families, trade unions, employers – that issues concerning the quality of life of children and adolescents are also of importance to the public at large.

The Conference discussed certain psychosocial problems of special importance. Each of these, presented in the following sections, is of such magnitude and complexity that it is possible only to highlight some of the important issues in each case.

3.2.2 *Psychosocial reactions to growth and development*

Inappropriate reactions to growth and development, including sexual development, are probably the most common psychosocial problems of children and adolescents. These problems are found in two types of children and adolescents: those with normal variations in growth and puberty who perceive themselves as abnormal because of their own ignorance or that of other people, and those with abnormal growth and/or puberty who develop secondary psychosocial problems. In both cases, the problems are rooted in a lack of knowledge on the part of children, parents, teachers, physicians, etc., of growth and development during this age period.

3.2.3 *Accidents*

Accidents are an excellent illustration of a present-day problem of children and adolescents: the problem has always existed but has been

obscured by the dominance of traditional infectious diseases; the problem is increasing, both relatively and absolutely, and this increase is related to modern technology and recent social change; the origins of the problem lie neither in disease nor deprivation but rather in environmental conditions (the cause, the effect and the solutions all involve psychosocial factors); we know a great deal about accident mortality but little about morbidity and traditional solutions are not applicable.

Accidents are the leading cause of mortality in children and adolescents in developed areas and account for one-half or more of all deaths in this age group. Road traffic accidents are the most common type of fatality and are significantly more frequent among male adolescents. While little is known of accident morbidity in children and adolescents, there is good evidence that it is high and serious. It has been reliably estimated that for every child who dies from an accident, another child will be permanently handicapped because of an accident, 10 other children will be hospitalized for approximately 30 days following an accident and 1000 other children will have an accident not requiring hospitalization.

The Conference emphasized that one of the underlying causes of the high frequency of accidents, especially in adolescence, is psychosocial. While the causal factors are multiple and complex, most of the important ones ("testing the limits" of the adult world, risk-taking to demonstrate supposedly adult bravery, the use of psychotropic agents, etc.) are related to the socially defined and forced extension of childhood into the middle and late teens and to the increased stress experienced by children and adolescents in modern society.

3.2.4 *Suicide*

While psychosocial problems are common in young people aged 5–18 years, serious psychiatric disorders are rare. The commonest psychiatric symptom is depression which, in the severest cases, can lead to suicide; this is the second or third most frequent cause of death in the age group 14–18 years in Europe. The nineteen-sixties saw a significant increase in suicides in teenagers aged 15 years and over and in the nineteen-seventies there has also been an increase in the suicide rate among those below 15 years of age. It is estimated that for every suicide there are from 3 to 10 attempted suicides.

The causes of suicide in children and adolescents rarely include psychosis but tend to be social in nature and related to stress in the family, school and society. Family conflicts are frequent and studies show a significant increase in both attempted and "successful" suicide during school examinations and when compulsory primary schooling ends and secondary schooling begins. Attempted or successful suicide in children and adolescents is associated with lower socioeconomic status, lower educational level, school

problems, social isolation, substance abuse, juvenile delinquency, and generally with those who may be called "social losers".

3.2.5 *Juvenile delinquency*

Juvenile delinquency is probably the most common form of social deviance in children under 14 years of age. There is evidence, furthermore, that it is increasing in most, if not all, areas of the European Region. Juvenile delinquency has been found to be correlated with a number of microsocial and macrosocial factors, which include: large family size, other delinquents in the family, lack of participation in youth groups, lack of religious beliefs, lower socioeconomic levels, working mothers, divorced parents, parental alcoholism, low aptitude, poor school achievement, truancy, residence in urban areas, and processes bringing about social disorganization such as rapid industrialization. It is not possible to establish simple causal relationships between the above factors and the occurrence of delinquency, especially as many of the factors are obviously interrelated. Furthermore, since the crime rates drop after children leave school, delinquency is probably to some extent related to poor adaptation to the school environment and may be seen as a reaction to its stresses and frustrations.

3.2.6 *Substance abuse*

The abuse of substances, including tobacco, alcohol, cannabis and "hard" drugs is widespread in children and adolescents in the Region. Although the harmful effects of tobacco smoking to the smoker and to those around him are well documented, the consensus of opinion is that the use of tobacco is a different phenomenon from the use of alcohol and drugs and should be considered separately. The use of tobacco by teenagers, while increasing in some countries, appears to be decreasing in others.

Alcohol and drugs are used by insecure or stressed children and adolescents to help them bear the weight of what is perceived to be a complex, hostile life. That they should choose these particular psychosocial "props" should not be surprising since adults, whom they emulate, are also increasing their consumption of alcohol and drugs (the drugs in this case being of the "soft" variety such as tranquillizers). A number of studies have documented the widespread use of alcohol by children and adolescents. While it is more difficult to determine the prevalence of cannabis consumption among young people, its use appears to be increasing in many parts of the Region. It also seems to have become a phenomenon of youth and early adulthood, either as a youthful alternative to alcohol or because of its availability in urban areas. It is not known whether the use of cannabis is intrinsically harmful or whether it leads to more dangerous drug abuse. The serious and harmful effects of the "hard" drugs (heroin, etc.) are unquestionable

and their increasing consumption among children and adolescents of the Region is a tragic fact. As these drugs are procured illegally, they become a factor contributing to juvenile delinquency, which was considered above.

3.2.7 *Related to schooling*

Since most children and adolescents aged 5–18 years spend a large part of their waking hours in school it is not surprising that many of their psychosocial problems as we have already seen, are affected by and affect their schooling. Some of these problems, however, result directly from their presence in school and it is these that we shall now briefly review.

The first set of problems comprises those related to school entry. School entry is a turning-point in the life of children and is inevitably a stressful period. The child must adjust to a new environment and the degree of adjustment required is directly related to the disparity between home and school. In families where the values, languages, attitudes and milieu are more distant from the school – poor families in non-poor areas, rural families in urban areas, migrant families, immigrant families – the stress of adjustment to the school setting will be greater than usual. A central issue is the degree to which a child should adjust to the school and the degree to which the school should adjust to the child. It is felt that at present too much adjustment has been required of the child and not enough of the school.

The child must also adjust to the pressure to perform. This pressure comes from all sides (parents, teachers, older peers) and results from the emphasis placed on education in industrialized society. As the institution responsible for training young people to serve a high-technology society, the school often adopts policies such as "streaming" (dividing students by performance levels), which greatly increase the stress resulting from the pressure to perform.

If the stress of schooling is too great, the child or adolescent may react by developing a psychosocial problem. These reactions are varied: at school entry school phobia is common; at older ages antipathy, truancy and school-leaving are more likely; psychosomatic symptoms are seen at all ages. In extreme cases, a quite small but significant number of suicides are associated with the stresses of schooling.

As society becomes increasingly technological, slow learning becomes a major problem. Slow learning, of course, is a common "symptom" for a variety of "diagnoses", e.g., retardation, dyslexia, perceptual motor dysfunction and social deprivation. The actual prevalence of this condition is unknown because of variations in diagnostic techniques, criteria, and reporting. To compound the confusion, there has been a tendency to apply a medical model in diagnosing, assessing and labelling, thus additionally burdening the slow learner with a clinical judgement which stigmatizes, stereotypes and often results in a self-fulfilling prophecy. Furthermore, this labelling

process, often based on the results of tests whose validity may be questioned, can cause the responsibility for the child to shift from the educational authority to the health authority. A largely social problem thus becomes medicalized and educational efforts are less enthusiastically pursued. Indifferent or insufficiently adapted students may be mistakenly grouped with slow learners, and this only serves to alienate them from and provoke hostility towards the school and society. Possibilities for the reintegration of such students are fewer and the school cannot perform its proper role of socialization.

If the educational orientation is solidly competitive and limited to high-status academic goals, a hostile and frustrating situation is created for the slow learner or nonadapted student, who frequently reacts in a self-defeating manner. Slow learners will seldom experience school as something stimulating and rewarding and easily develop a negative self-image, accepting the role of the loser, the incompetent and even the unlovable. This attitude of resignation is a serious obstacle to further intellectual development, resulting in a high proportion of early school leaving and a serious loss of human capacity.

3.2.8 *School leaving and work entry*

Three aspects of modern industrial society are responsible for problems related to school leaving and work entry: the trend towards prolonged, mass, general education; the fact that education is the key to social mobility; and the fact that the economic crises of recent times make it less and less likely that adolescents will be able to realize their chosen vocational aspirations. These factors provoke parental and school pressure on children and adolescents and result in stress.

When young people leave school and enter the labour market they come face to face with the disproportion between the high requirements for job qualifications and the low potentiality for their attainment. The result is widespread unemployment (highest among the young) and/or inappropriate employment (young people obtaining jobs which are below their qualifications and education). Whether the underlying issue is unemployment or inappropriate employment, the realities of today's job market lead to a decrease in job suitability for young people.

The stresses resulting from prolonged schooling and a lack of suitable employment contribute to the adolescent's feelings of inadequacy and alienation from society, and these in turn may lead to psychosocial problems. One reaction which is becoming more common is to withdraw from the contest and leave school before the completion of studies. Beyond this, practically every form of deviant behaviour found in the adult world – alcoholism, drug abuse, crime, etc. – may be found among adolescents as reactions to the stresses of school leaving and work entry.

3.2.9 *Related to leisure*

The development of personally satisfying and socially appropriate leisure activities is an integral part of the socialization of children and adolescents. The present-day industrial revolution, while resulting in more leisure time, has also resulted in more "brain-work", hence the need for leisure which promotes a fuller, more balanced life. As children gradually leave the family setting they need to become involved in their own activities which will form the basis for their life-long patterns of leisure.

The organization of leisure activities for children and adolescents in industrialized society presents several problems. First there is the issue of finding the proper balance between adult-initiated and supervised leisure and self-initiated and self-controlled leisure. To what extent should leisure activities be purposeful, useful and ennobling, and who is to define what is useful, the adult or the young person? Is it possible to plan or organize arrangements to meet the young person's real need for idleness and contemplation? If adults organize children's leisure time in the same way that they organize children's educational time, the result may be alienation through leisure – a feeling on the part of the children that their lives are overorganized and a wish to rebel against such control.

A second problem in the organization of leisure activities concerns the role which these activities should play in providing for optimal physical development. Where is the borderline between physical education, which is part of the child's work (school), and physical culture, which is part of the child's play (leisure)? To what extent should physical culture programmes be devoted to physical activities and games for all children and to what extent should they be devoted to the development of the optimal physical abilities of the athletically gifted? What are the physical and psychosocial risks to children and adolescents involved in competitive sports?

Another issue in relation to the leisure activities of children and adolescents is the role played by television. More and more young people are spending a large number of hours watching television. Most "children's programmes" are designed for preschool children, adult programmes are all too often filled with violence and there is little or nothing appropriate for the age group 5–18 years. What is the effect of this extended television-viewing on the physical and psychosocial development of young people?

While handicapped and chronically ill children and adolescents also have leisure needs, the limitations imposed by their condition often produce boredom and an exaggerated need for leisure. At the same time, these limitations imply that considerable creativity and innovation is required in devising leisure activities for such children. Possibilities for leisure pursuits should be provided at home, at school and in any other appropriate setting.

4. SOLUTIONS

The Conference prefaced its discussion of solutions to the problems of children and adolescents in modern society with the following observations:

(1) Information concerning the problems of this age group is insufficient; this lacuna is primarily due to a lack of basic research, but it is also due in some measure to the difficulty of identifying problems by traditional methods of investigation in a changing societal context and in an age group which is itself characterized by its developing or dynamic nature.

(2) Information concerning the effectiveness of present services in solving problems which have already been identified is inadequate.

(3) Our knowledge of the problems of children and adolescents today nevertheless clearly indicates that the nature and focus of present services should be changed now, both to meet new needs and to provide new approaches to unsolved problems, and that correlated research should be incorporated in any programme for changing such services so as to assure new and more appropriate data for the future.

The solutions arrived at by the Conference were defined by or based on several underlying principles. The first is the need to focus attention on the normality of childhood and adolescence, on health rather than disease, and on the impact of any solution on the quality of life. Research must include more information on the qualitative aspects of normal growth and development and make greater use of positive indices of health. Services must place greater emphasis on health promotion and the normal needs of young persons, whether sick or well. Education programmes should be directed towards the positive encouragement of self-directed behaviour which leads to a satisfying life.

The second principle centres on the need to integrate the various solutions. Changes in services for children and adolescents should be directed towards integration in its various aspects: integration of health, education and social services; integration of traditional and nontraditional approaches; integration of family, school and community. Such integration will require increasing team efforts, bringing together a wide variety of disciplines – education, nursing, medicine, nursing-midwifery, psychology, sociology, law, architecture, politics, engineering, etc. – in varying combinations in which the medical members may not be assumed to be the team leaders. Such integration will also require a breaking down of traditional service roles, decreased use of the medical model as the basis of approach and an expansion of less traditional health, educational and social programmes.

The third principle is that a greater role should be given to the individual and the family in defining problems and in devising and participating in their solutions. The nature of the new problems of children and adolescents demands that the individual and the family be actively involved as full partners in health care and social care and in the educational process. What individuals do to and for themselves, each other and their children has a far greater impact on the health and the quality of life of children and adolescents than that resulting from encounters with professional services of all kinds.

The fourth and final principle is that the solutions proposed should be practicable and not require significant increases in funding; rather, they should be achieved through a redistribution of existing resources. There are a number of reasons for this: outdated activities which no longer meet present needs can be abolished; institutional care of children and adolescents can be reduced and support to families and schools can be increased; the cost-benefit ratios of preventive and promotive activities can be measured. Planning can begin with innovations in services which do not call for a substantial allocation of additional funds.

The solutions will be presented here in four categories: research needed, changes in health services, changes in general services, changes in manpower training, but their interdependence will be apparent.

4.1 Research

As stated above, our knowledge of the problems of children and adolescents in modern society and of the effectiveness of present services is inadequate. We may obtain the knowledge we need through four types of research. The first is aimed at more clearly defining a problem. Since the nature and extent of a given problem is likely to vary, depending on local conditions, each country must determine the characteristics of its own problem, using careful epidemiological analysis of available data and, when necessary, systematically compiling new data. A second type of research is that aimed at determining the causes of a problem, causes which are usually multiple and general. This type of research must often be multidisciplinary and must include the behavioural and social sciences.

The third type of research that is needed is health services research directed towards all existing services for children and adolescents. Through controlled scientific study the actual activities performed by a given service can be determined and, in turn, related to the presence or absence of output indicators (desired results). A fourth type of research is the development of experimental programmes in which innovative services are tried out and their results carefully measured. Based on this information, such experimental programmes may be further modified and may ultimately be used as models for launching new service programmes.

4.1.1 *Research on normal growth, development and behaviour*

As mentioned in section 3.1.1, better standards of physical and sexual growth and development are needed. Research should include: the development, by each country, of its own standards based on a representative sample taken at least every 10 years; analysis of the influence of environmental factors; the study of functional components, and a search for better parameters, including ones which can be measured by non-physicians. At the same time, reliable standards and an adequate assessment of the psychological and social development of children and adolescents are sadly lacking. If such standards can be established through research, then it will be possible to construct an individual developmental profile[a] (including biological, psychological and social parameters) by means of which desynchronization in a young person may be detected and assistance given.

We have seen in section 3.1.7 that little is known about the development of sexuality in young people. Such knowledge is essential if we are to develop rational services for such problems as unwanted adolescent pregnancy, induced abortion and sexually transmitted diseases. Research should include information on: sexual practices, contraceptive practices, decision-making with regard to abortion and childbirth; patterns of living together and family formation.

Since it is accepted that the socialization process in children and adolescents is critical to health development and since our understanding of this process is as yet meagre, there is an urgent need for further research on this aspect of development. A study of the role of the family in the socialization of the child should examine the changing role of women, the problem of working mothers, the expanding role of fathers and the changing role of siblings.

The role of the school and the local community in the socialization process has to be more explicitly defined. The effects of urbanization and socioeconomic deprivation on the social development of children and adolescents also need to be explored; how, for example, is socialization affected by migration to a city, crowded living conditions, or living in high-rise flats?

4.1.2 *Research on morbidity and mortality*

As stated earlier, data on morbidity in children and adolescents is sparse, inadequate and biased. More information is urgently needed on the new morbidities of children and adolescents in more developed areas, and particularly on the prevalence of chronic conditions and handicaps, the prevalence of "minor" conditions which nevertheless influence the quality of

[a] For an example of such a developmental profile, see report on the Working Group on Problems of Children of School Age (10–13 years) (ICP/MCH 008)

life, and the prevalence of psychosocial problems. The key role which school health personnel might play in collecting such data will be discussed later.

The fact that the mortality rate from violent deaths appears to be rising in several industrialized countries in the Region certainly needs further investigation. The question of whether "overdevelopment" is accompanied by increasing death rates, even in children, also needs to be answered.

4.1.3 *Research on specific biological problems*

The characteristics of infectious diseases in children and adolescents in more developed areas have changed and data on the new epidemiology of these diseases are needed. Similarly, the situation with regard to immunization has changed in ways of which we are still ignorant. Studies of infectious disease prevalence and immigration levels should be followed by experimental programmes with built-in evaluation components.

A second biological problem on which research is needed is nutrition. Each country should survey the nutritional status of children and adolescents and identify nutritional risk groups. Such surveys should include the grouping of nutritional risk under headings ranging from undernutrition to overnutrition, thus providing basic data on the prevalence of such conditions as childhood obesity. In a similar fashion, national surveys on the eating practices of children and adolescents could provide valuable and as yet unavailable data on the use of convenience foods and the frequency of collective feeding.

These studies should then be followed by attempts to determine the causes of common forms of malnutrition such as obesity. Research of this kind must necessarily be multidisciplinary, as nutritional status is affected by social, emotional, geographical, economic and other factors. At the same time, such research could begin to explore the long-term effects of childhood nutrition on health and disease in later life.

Nutritional research should also be incorporated into experimental programmes to prevent malnutrition (incuding overnutrition) in high-risk groups and to treat children and adolescents with nutritional deviations.

4.1.4 *Research on specific psychosocial problems*

Four major problems, all basically psychosocial in origin, call for further research: accidents, suicide, juvenile delinquency and substance abuse. These four problems will be dealt with together here because they all require the application of the four types of research referred to earlier.

The first type of research is aimed at defining the problem more clearly through epidemiological analysis. In the case of accidents information on morbidity and risk groups is needed. A careful registration and detailed epidemiological analysis of attempted suicide (morbidity) and suicide (mortality) is a basic need in every country. Such analysis should include the

relationship of suicide to such social factors as family changes and schooling. The extent of juvenile delinquency and the form in which it is manifested vary greatly depending on local conditions and, for this reason, require local analysis. A better understanding of the demographic characteristics of substance abuse is essential in every area of the Region. Thus, the first step towards the solution of all four problems is careful analysis, at national and local level, of the characteristics of affected individuals and of their relationship to various social factors.

The second type of research is aimed at determining primary causes and this implies further study of the process of socialization. Faulty socialization (deviant and nondeviant) is certainly an underlying cause, whether the outcome in an individual case is an accident, suicide, juvenile delinquency or substance abuse. Here research can include both more basic studies of the process of socialization itself and studies of the faulty socialization of individuals who exhibit one or more of the four problems.

The third type of research is evaluation of services. Present services (including educational programmes) for accidents, suicide, juvenile delinquency and substance abuse have not, in general, been very effective. Careful evaluation of their impact or the lack thereof is necessary if mistakes are not to be repeated and if more effective approaches are to be found. Service research is a relatively new field and now that reliable methodologies have been developed, it is being given high priority in the WHO European Region.

The fourth type of research – experimental programmes – grows out of the three other types of research. Armed with a better understanding of the extent and nature of the problem, its underlying causes and its relationship to social factors, and the successes and failures of existing services, one can design and plan experimental programmes. Such experimental programmes can be preventive in nature, e.g., telephone "hot lines" and mutual-aid groups for those contemplating or attempting suicide, new educational approaches to accident prevention, or curative in nature, e.g., new approaches to the rehabilitation of juvenile delinquents and drug addicts. These programmes have two essential ingredients: innovative services and built-in evaluation of results. Because these psychosocial problems are serious, increasing, and as yet resistant to attempts at their solution, experimental programmes for all four are imperative.

4.2 Health services

The Conference agreed that the problems of children and adolescents in the more developed areas are not being met by traditional maternal and child health programmes. A reorganization of health services, with new roles and functions for health workers, is required.

4.2.1 *Organization of health services*

Within the health care system for children and adolescents the largest and most important services are those directed at primary health care. Primary health care has now received universal recognition as being of the highest importance in the future development of health services.[a] It should be available at community level, and should include full community participation. Whenever possible, this care should be preventive and multidisciplinary in character, the older forms of individual medical practice being replaced by teams. Such teams will make extensive use of nursing personnel, including public health nurses, nurse practitioners and nurse aides and, in addition, will involve other less health-oriented members such as social workers and community aides. The health professionals on such primary care teams can serve as catalysts in the development of integrated primary care by facilitating greater communication among all team members.

Primary health care for children and adolescents includes not only preventive and curative services but also traditional and nontraditional approaches. Traditional primary health care services are the formal professional medical services (provided by the doctor, nurse, school doctor, etc.) which are suitable, in general, for managing the more traditional health problems. While these traditional services are organized in a variety of ways in the European Region, they all fulfil several key functions. The provider of traditional primary health care services must first be able to communicate with children and adolescents, i.e., to provide a service which is both accessible and acceptable.

The process of socialization in young people often produces in them feelings of suspicion towards adults. The provider must find ways of overcoming such suspicion by gaining the confidence of the child or adolescent. Another necessary function of traditional primary health care services for children and adolescents is that the service provider should be able to communicate with the other elements in the service network: secondary and tertiary health, social, legal, educational and nontraditional services. All countries need to evaluate their primary care referral systems and raise the status and respectability of nontraditional services within the traditional sector.

The nature of the present-day problems of children and adolescents dictates that traditional primary care services for this group should be supplemented by nontraditional services. The bureaucratic nature of traditional services, characterized by waiting lists, fixed consultation hours, appointments, etc., often conflicts with the needs of children and adolescents, while their use of older, highly trained adult professionals often produces feelings

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[a] See: World Health Organization. *Primary health care.* Report of the International Conference on Primary Health Care, Alma-Ata, USSR. Geneva, 1978.

of antipathy. Nontraditional primary care services for children and adolescents should therefore have a nonbureaucratic, nonprofessional approach which would include some or all of the following features: being open during the evening; operating on a "walk-in" basis; maintaining a casual, "nonprofessional" ambiance; permitting access without parental permission; guaranteeing anonymity. These nontraditional services, such as clinics for problems of substance abuse or for sexual problems, may be set up to meet specific, urgent local needs, or they may be established to meet all the primary health care needs of children and adolescents who, for one reason or another, will not avail themselves of traditional services.

Emphasis on self-care and on peer help is one of the common characteristics of nontraditional services. In the past, traditional services have tended to ignore or minimize the importance of the contribution that can be made by the individual and his peers to his own care. Nontraditional services have tapped this resource to great effect. These methods can also be incorporated in the more traditional sector, gradually reducing the differences between the two types of services.

Primary health care for children and adolescents includes school health services. Most school health services today are rather isolated from the rest of primary care and tend to concentrate on the status of physical health. It is strongly recommended that this be changed and that emphasis be placed instead on a team effort in the school since each member of the school team (physician, nurse, teacher, psychologist, social worker) has his or her own part to play in solving the complex psychological problems of children and adolescents.

Such a change in school health services, however, means that new roles have to be assigned to school health personnel. The school physician at the present time functions mainly as a practising primary care doctor involved mainly in preventive clinical activities. Too often the function of the school nurse is to give first aid and maintain health records. The new roles of the school health physician specialist and school health nurse specialist would be identical to those of other health care specialists, namely, consultation and research. The physician's and nurse's intimate knowledge of the school milieu, combined with their detailed knowledge of the many aspects relating to the health of children aged 5–18 years – school entry; placement of chronically ill children; limitations on physical activity by age, size and sex; nutritional patterns and risk groups; accident morbidity and mortality patterns, etc. – equips them to act as specialist consultants to the team which is responsible for the formulation of policies in the school and community and for the management of individual children and adolescents with problems.

This knowledge of children and adolescents and of the school and community in which they live also makes school health personnel ideally suited to conduct important research. This can be basic research aimed at increasing our knowledge of such features of the health and morbidity of children

and adolescents as nonfatal accident patterns, infectious disease and immunization patterns, eating practices (including collective feeding), nutritional levels and risk groups, patterns of school absenteeism and early school-leaving, and the relationship of depression and attempted and successful suicide to school policy and school activities. It can also include action research which systematically evaluates existing school health services and their outcomes and which creates new systems of care and measures their results. Physicians and nurses who wish to become such school health specialists would need to increase their theoretical and practical knowledge systematically in many areas. As the status of school health personnel rises, so too does the status of the school health programme and this, in turn, increases the possibilities for better information exchange and the integration of primary care services.

A country's first concern must be to develop a good primary health care system for children and adolescents, using the basic family medicine system (paediatrician or general practitioner) of that country. Children and adolescents, however, also need to have access to secondary and tertiary health care services.[a] Those requiring such services still have the usual needs of all children and adolescents. Thus, for example, during hospitalization it is important to ensure that confidentiality between the patient and the health team is maintained, that the patient fully comprehends all his problems, that his schooling continues, that he is given the company of peers to allow continuing socialization, and that visits by friends and family are permitted. Satisfying these needs clearly requires the services of a multidisciplinary team (doctors, nurses, social workers, teachers, psychologists) and is best accomplished by locating the patient in a special unit for children or adolescents. It is strongly recommended that children should not be placed in hospitals for specific diseases since, no matter what services are provided, the child's environment places the emphasis on pathology rather than on normality. If the adolescent patient population of an institution does not justify a special adolescent unit, then placement in a children's or an adult unit should be decided on an individual basis, taking into account the development level, not the age level, of the patient.

4.2.2 *Content of health services*

4.2.2.1 *Surveillance.* In an age group characterized by low mortality and large numbers of healthy individuals, surveillance is the key to the identification of problems. The dynamic character of the new problems and the paucity of information on related morbidity make it difficult to formulate

[a] Secondary health care involves management by medical specialists, including hospitalization. Tertiary health care involves management by the most highly specialized and technical services, such as intensive care units and cardiac surgery units.

general criteria for the selection of those problems which require surveillance and those conditions which should be the object of screening. At the same time, the question of where responsibility for such decisions should lie must also be asked, for health professionals, educators, parents and young people often perceive "problems" and "needs" quite differently. Health and education specialists have knowledge of the available data on mortality, morbidity and allied matters, but they are often unfamiliar with the real problems and needs of children and adolescents in their daily lives in the family and community. Decisions on surveillance programmes should therefore be taken by all those concerned, including parents and the young people themselves.

As new problems are identified, the old methods of screening become less and less appropriate. For example, a clinical physical examination by a physician, the cornerstone of the traditional school health programme, is found to be ineffective in identifying nearly all the present major causes of morbidity and mortality in children 5–18 years of age. The psychosocial nature of many problems demands the development of new screening methodologies which include measurement of functional capacity. Screening should be conducted at key periods of life, such as school entry and puberty, which are accompanied by important changes calling for greater physical and mental outputs. So far as is possible, methods should be found which can be applied by nurses, technicians, trained parents or other lay people. The procedure of classifying deviations and recording results should incorporate three principles: classification should be based on the concept of risk; it should not only include readings ranging from healthy to sick but should also cover the full range of functional capacity; it should include a category for children who have no measurable deviation but who may encounter problems in the future.

Precautions should also be taken to avoid the detrimental effects of screening. A first danger is labelling : it is very easy to apply a diagnostic label but very difficult to erase the label and its results afterwards. A second danger is identifying problems for which solutions are unavailable or unknown since this, justifiably, leads to anxiety, frustration or anger on the part of the child and his family. A third danger is identifying problems for which treatment is questionable or for which there is a risk of overtreatment (e.g., screening for enlarged thymus glands, enlarged tonsils and retractile testicles).

4.2.2.2 *Services for biological problems.* A programme for the development of basic health services for children and adolescents must include those elements which can help serve as solutions to the problems referred to above. With regard to problems of growth and development, real or imagined, it is essential that, when dealing with patients, all health workers recognize the importance of teaching the principles of growth and development to

children and to all those who work with them. Problems related to sexual development require special attention. In order to prevent unwanted pregnancy and unwanted childbirth and reduce the incidence of induced abortion and sexually transmitted diseases, sexual counselling, contraceptive counselling and any necessary treatment should be available in every basic health service for adolescents. Since, as we have seen, teenagers are often reluctant to seek medical advice from traditional medical sources on their sexual problems, serious consideration should be given to the development of other, nontraditional, sources from which they can receive sympathetic, anonymous, nonreprehensive, competent care (teenage "hot line" telephone service, evening youth club clinics, etc.).

Every basic health service for young people must also include a system of management for chronic diseases and handicaps, based on three principles of care. The first is the need to emphasize and enhance the normality and overall welfare and development of the individual suffering from a chronic condition. As stated earlier (section 3.1.3), the medical care system's tendency to focus on abnormality has contributed to the handicapping process. The second principle is that of early intensive treatment to reduce social and emotional sequelae and to provide the child with the best possible preparation for schooling and later life. The third principle in the management of chronic conditions is to develop a system which integrates the care in the medical sector with that given in the home, school and community.

The implications of these principles for the family and school will be discussed later (section 5) but a few observations with regard to the health care system are in order here. Medical care personnel are gradually becoming aware that it is both necessary and possible to increase the role of the family and the child himself in the management (including actual medical treatment) of a chronic illness. In certain chronic diseases such as diabetes, family and self-management has long proved effective medically, psychologically and socially. More recently, increased family and self-management have been found most effective in other chronic illnesses in children and adolescents, such a as haemophilia. The obvious advantages of such self-care, both to providers and to consumers of health care, make it imperative to encourage the continued expansion of this method of care in other chronic conditions.

Normalization of the medical management of chronic conditions includes consideration of where management should take place. Outpatient management, with the child living at home, is clearly the most normal and preferred procedure. Children are often hospitalized unnecessarily, at least in part because of the resulting convenience for the medical staff. Management regimens for the various chronic diseases of children need to be re-evaluated in the light of the latest technical advances, the possibility of making greater use of other types of personnel (e.g., home nurses), and the development of transportation systems and family education programmes, so as to determine the maximum extent of possible outpatient management. When inpatient

management is unavoidable, alternatives should be developed such as day wards (nights are spent at home or with the family in a "hotel" attached to the hospital), weekday wards (weekends are spent at home or in the "hotel"), or non-hospital-like facilities ("schools", or "sanatoria" with nursing services). These alternatives should resemble the normal environment as far as possible. When the more standard type of hospital inpatient management is necessary, careful consideration must be given to the hospital environment, since hospitalization affects the physical, mental and social development of children. Young people should be hospitalized in children's departments or adolescents' departments, regardless of the nature of the disease. Such departments should provide education, recreation and frequent contact with family and friends. Finally, periods of inpatient management should be as short as possible.

Since children and adolescents with chronic health conditions have all the normal needs in addition to the special needs associated with their particular health problem, and since they usually require not only secondary or tertiary health care but also special educational and vocational attention, they place the highest demands on the health care system. These demands can only be satisfied by a carefully coordinated, multidisciplinary system of services involving health, educational and social services personnel.

Basic health services for children and adolescents must include programmes for the prevention and control of infectious diseases. These programmes should be adapted to the local community, taking into account information on economic conditions, health behaviour, health services as well as epidemiological data on local disease prevalence. They should ensure that all children receive appropriate immunizations prior to school entry and continuing during the school years. Current school policies on the control of infectious diseases, including the practice of keeping children away from school, should be carefully re-evaluated in the light of the latest information concerning communicable diseases. For example, many highly regarded paediatric specialists in this field are now recommending that children with symptoms of upper respiratory disease but without fever should not be kept away from school since they have already passed through the most contagious presymptomatic stage of their illness. School policy in this area should also take the family situation and the educational needs of the child into account.

Basic health services for children and adolescents must, in addition, include nutrition programmes appropriate to the nutritional problems of the area they serve. Since the most common form of malnutrition in children and adolescents in industrialized countries is obesity, services should provide means of identifying individuals who are obese or at risk of becoming obese. Services for the management of such individuals must be multifaceted, involving the family and school in addition to medical personnel.

Health personnel must also be involved in collective feeding programmes for children and adolescents. By serving as nutritional consultants to collective feeding establishments (school canteens, youth club canteens, etc.), health personnel can ensure the quality of the food served in the context of the total nutrition of children and adolescents and, in addition, can ensure that the young people, their families and the community are all involved in the planning and perhaps the preparation of the food served.

4.2.2.3 *Services for psychosocial problems.* Health services for children and adolescents may include programmes aimed at helping solve some psychosocial problems. Since each of the psychosocial problems discussed above is widespread and of serious import and since these problems all have health consequences, health service personnel must be involved directly or indirectly in developing solutions to these problems. Often this involvement will consist in their serving as catalysts to stimulate the development of better services. This can be followed by continuing collaboration with other disciplines or services to ensure proper integration of the services with the health sector. To be effective, services for psychosocial problems must include the following: collaboration among educational, social, legal and health services; more emphasis on nontraditional approaches; and the involvement of young people, families, schools and the community in planning, operation and evaluation.

The role of health services in programmes for the prevention and treatment of suicide should first include the stimulation of more and better family support systems and better school policies (see section 5). Armed with morbidity and mortality data on suicide as it relates to local conditions, health service personnel can raise public awareness of this problem. The health services, in collaboration with other services, can also develop special programmes such as telephone "hot lines" and mutual aid groups for young people at risk of attempting suicide.

In view of the gravity and magnitude of the problem of substance abuse by young people, every country should develop more and better services for dealing with this problem. Health workers see the tragic results of substance abuse and it is they who must raise the cry for action by widely disseminating the facts. Intervention programmes can be established in schools and incorporated in existing programmes. Innovative approaches can be tried, such as those using significant models (including remote heroes and peer group leaders) who have successfully tackled or overcome the problem of substance abuse and have found more positive solutions to their stresses. Special programmes, such as youth advisory services,[a] can also be mounted.

[a] See: **WHO Regional Office for Europe.** *Youth advisory services*: Report on a Working Group. Copenhagen, 1976 (ICP/MNH 016 III(1)).

The complex nature of juvenile delinquency requires an integrated approach. Health workers can contribute by changing our perception of offenders from that of "bad" children and adolescents in need of punishment to that of individuals suffering from faulty socialization as a result of deprivation of one kind or another. To this end, health workers can collaborate with the legal and social services in finding innovative solutions which are less punitive and stress rehabilitation through better socialization.

Although accidents are basically psychosocial in nature, their obvious health consequences demand that the health sector lead the way in finding better solutions. By making accident mortality and morbidity data widely available and relating them to specific local conditions (e.g., dangerous street corners, poisons most frequently ingested), health workers can press for changes in policies, laws and local conditions and stimulate local community action.

4.3 Health education (including education in sexuality)

Health education presents an extraordinary paradox. While everyone agrees that it is probably the most important instrument in the development of a healthier population, everyone also agrees that, to date, it has been either seriously neglected or, when not neglected, for the most part ineffective. While there must be a number of reasons for this state of affairs, one explanation is that present-day health education for children and adolescents, like the health services for them, reflects traditional health problems. The content of these educational programmes emphasizes physical disease and physical hygiene, while the methodology reflects an overprofessionalization, characterized by a paternalistic and seemingly dictatorial approach. Existing programmes focus on increasing knowledge despite the fact that knowledge alone does not lead to changes in health behaviour.

Since the ineffectiveness of health education programmes must, at least in part, explain their neglect, the only way out of the dilemma is to redefine the goals of health education and develop innovative methodologies which are more effective. This must be a broad effort, involving not only health educational personnel but also psychologists, sociologists, parents and children.

In redefining the goal of health education, the Conference agreed that the general aim of health education programmes for children and adolescents should be that of improving the abilities of the individual to use his own resources for his own health and health care and to make effective decisions based on the information acquired. To achieve this, it is imperative that children and adolescents be taught the truth about health and health risks, and that they learn to identify symptoms of ill health and how to deal with them. The concept of community health should also be promoted by providing young people with the knowledge, skills and opportunity to solve

public health problems in their own community. At all times emphasis should be on the benefits of a state of wellbeing rather than the negative effects of ill health.

In developing innovative methodologies in health education, three basic principles should be borne in mind. First, since health is a means, not an end, and since neither health nor the acquisition of knowledge are in themselves incentives for children, health education programmes must be challenging, enjoyable and relevant to everyday life. The wider and more effective use of mass media and of hero-figures (actors, sports champions, etc.) are methods that urgently require further development.

A second principle, integration, has several facets. Health education programmes for young people must integrate the home, school and community so that learning may take place in a consistent way and involve all aspects of the child's daily life. Such programmes must be integrated methodologically, i.e., the teaching methods should be geared to the developmental level of the individual. For example, since teenagers tend to be suspicious of adult authority, less traditional methods are needed which are aimed less at directing behaviour and moralizing than at emphasizing the facts and risks, leaving the choice to the individual, allowing him to find out for himself through trial and error, encouraging him to care for himself and providing him with the knowledge of when and where to seek information and advice. The programmes should also be subject-integrated. The subjects taught should be age-specific and relevant to the present needs and problems of the child; they may be integrated in the rest of the "non-health" curriculum of the school and thus relate health to the rest of life in a realistic manner.

The third methodological principle of health education is that children and adolescents should participate actively in the learning process. On an individual basis this can take the form of expanding the role children play in managing their own illnesses, since learning is very effective when it is applied to oneself in a concrete situation. On a group basis it can take the form of a community health action programme. Such a programme can involve an entire community, including schools, local government, adult organizations, the mass media, etc., in solving one of its own health problems. Young people can participate in meaningful, goal-directed activities which contribute to the solution of the problem. Such programmes have been found to have a significant effect on the health behaviour of children and adults in a specific area and have brought the community into closer collaboration with the schools. The school community projects are consistent with the method whereby, instead of being told what they must or must not do, people are provided with all the available data on a given health problem and encouraged to choose their health goals, both individually and as a group, and to determine ways of achieving them.

The essential role of health education as part of the solution to a number of the present problems of children and adolescents needs elaboration.

The need for education concerning normal growth and development has already been indicated. Learning about the hiatus between biological age and chronological age will help reduce inappropriate psychosocial reactions to normal variations in biological development. Learning about psychosocial development will enable the individual better to adapt to his own development and to accept the psychosocial variations of his peers.

Health education concerning biological problems can be related to the daily lives of children and adolescents. Nutrition education can be related to their meals at school and can help them adapt their eating practices to ensure good nutrition; education in infectious diseases can illustrate the principles of integration and participation. The programmes can be a team effort in which the child can learn through active involvement in the management and control of illness in the school. He can be taught by school health personnel to initiate care of himself at the onset of acute illness. Individuals in the classroom can be selected to control heating, ventilation, etc. Teachers can use the latest information to help children learn about infectious disease control. School health personnel can serve as consultants to establish school policy and consult with teachers and children. Parents can work with the school to establish policy on infectious disease control in the home, school and community. School pupils can participate in collecting data on immunization levels in the community and in bringing community members needing immunization to care. (During participation in such a project the children will learn something about population dynamics, simple statistical methods, the principles of epidemiology, the characteristics of infectious diseases and immunization, the provision of preventive health services, the characteristics of patient cooperation and resistance, the geography of the neighbourhood, mathematics, etc.)

Health education for psychosocial problems is crucial and in need of development. While the goals of such education cannot be expanded upon here, it should emphasize changing stress-producing social pressures and finding less harmful ways of alleviating stress.

The Conference gave special consideration to the need for education in sexuality and living together. Earlier discussions in this report on sexual development (section 2.2) and problems associated with sexual development (section 3.1.6) have made it apparent that there is an urgent and increasing need for this type of educational programme. The increasing period of risk of unwanted pregnancy has resulted in growing numbers of pregnant adolescents. While induced abortion may be better than an unwanted child, contraception is better than un unwanted pregnancy, and the best path to improved contraception is education that promotes responsible sexual behaviour. Increasing sexual activity among teenagers is a fact and, rather than ignore its existence or try to stamp it out, it would seem more expedient to educate young people so that such activity becomes a positive and constructive experience in the developmental process. Cohabitation is also

increasing, at least in some areas, and since most people eventually marry, it is equally important to teach young people how living together can be a positive and constructive experience.

In spite of this urgent and increasing need for education in sexuality and living together, the present situation in this field gives cause for concern. A survey of programmes of education in sexuality in 16 countries in the European Region, performed in preparation for the Conference, revealed the following: in 5 countries these programmes are compulsory and applied in all schools; in 5 countries the programmes have received legislative approval but have not been uniformly applied; in 3 countries they have been officially approved but have not been sanctioned by legislation; in 3 countries they are not prohibited but are virtually undeveloped. The age at which these programmes begin varies: in 5 of the countries surveyed it begins with pre-school education but in the others it usually starts only at the secondary level. The curriculum content varies widely among countries: in some countries it includes only biological information and rarely includes any information on contraception. Books on this subject are seldom prescribed as compulsory reading and in some areas no such books exist. Specialized institutions, health education committees and voluntary family planning associations play an important role in a number of countries in preparing material and stimulating programme development. Only 4 countries included in the survey use radio and television in such programmes.

The reasons for this serious lag in the promulgation of education programmes in sexuality are multiple and complex. For example, the rapid evolution in patterns of sexual behaviour in young people means that today's adolescents discover sexuality in a different way than today's adults did. This leads to adult anxiety and uncertainty concerning what should be taught. As a result we find inadequacies even in those countries of the Region which have long-established and highly developed programmes of sex education. On the other hand, the exception which proves the rule is that in the only country in the Region which has experienced a recent significant decrease in the adolescent pregnancy rate, the decrease is almost certainly due to an increase in contraceptive activity as a result of an extensive education programme in sexuality.

In discussing the content and form of education programmes in sexuality, the Conference made several recommendations which it considered essential to the success of such programmes. First, sex education should be broadened to family life education and should provide information concerning sex roles, parental roles, child care and family interaction with the aim of forming a complete and socially active personality, prepared for a happy life with a partner and a sound family. The emphasis of these programmes, which in the past has been negative (prevention of pregnancy, prevention of sexually transmitted diseases), should be on the positive aspects of sexuality: planning for wanted children, and the achievement of rewarding, loving human relationships.

These education programmes in sexuality should begin early, be age-specific and be a continuous health promotional activity throughout the school years. They should start in the family with a preschool child and be linked to the school. During the early school years teaching should focus on all aspects of normal sexual development (biological and psychosocial), including normal variations. By 13 years of age children should have received all the necessary sexual and contraceptive information (facts) in order to prevent unnecessary anxieties and unwanted pregnancies during their pubertal years. During the adolescent years the curriculum should include information on variations in sexuality, such as homosexuality, and on sexually transmitted diseases, their symptoms, their consequences and their prevention, and should place emphasis on preparation for living together, family life and parenthood. The more specific content of the programme should be determined locally, in the light of local conditions, mores, etc., and have the endorsement and backing of the community.

Special attention should be given to appropriate methodologies for developing these programmes. Teaching should take place in and out of the school classroom, in the doctor's office (during medical examinations), in youth clubs, in nontraditional youth clinics, as well as in the home. Teaching should be on both an individual and a group basis and should involve parents, psychologists, physicians, nurses, social workers, informed peers and other members of the teaching staff. Teachers for such programmes must be chosen with care. Medical personnel have a role to play in training teachers, counselling young people and serving as consultants to stimulate better programmes.

The Conference recommended that educational programmes in sexuality and living together be made compulsory in schools by means of legislation. Each country should accept the responsibility for creating legal structures which provide an adequate mandate and support for such programmes. Countries should also be aware of and prepared to counteract the commercial exploitation of sex.

4.4 General services

General services are those services which, in addition to health services, contribute to solving the problems of children and adolescents. Such services, which include social, educational and legal services, need to be integrated with each other and with health services at both the provider level and the consumer level. At the provider level this should begin internationally, with closer and continuing collaboration among international organizations involved with children and adolescents such as WHO, UNESCO and UNICEF. At the national, regional and local levels the planning and implementation of all services for children and adolescents should be integrated to the greatest possible extent.

At the consumer level, services for children and adolescents are given in the family, the school and the community. General services will be divided here according to these three settings, but the overlapping of such services and the need for their integration is clearly demonstrated by the example of vocational education, which takes place in all three settings and involves education, health services (including psychosocial), social services, industry, etc.

4.4.1 *Services for families*

The family in modern society is changing profoundly. Recent changes in technology have had social, demographic and economic consequences such as changes in employment and housing conditions due to urbanization and industrialization, and these changes have had a major impact on the family. The importance of the family and of informal neighbourhood networks has been weakened and the role of family members has changed. The growing tendency of women to continue gainful employment after childbirth may be unfortunate in poor, uneducated families where such employment represents an additional burden on the woman. However, the employment of women cannot be viewed only as a negative factor, since it can be conducive to increased self-expression and personal development of the mother, a widening of the father's role in child care and household management and an improvement in the economic situation of the family.

Despite these changes, the family continues to assume primary responsibility for the upbringing of children and plays a central role in the process of children's socialization. For this reason more and better family support systems should be developed as one of the primary solutions to the problems of today's young people. Family support systems should be improved by strengthening both the professional services (health, educational, social, legal, economic) available to families with children and the lay services (self-help groups, mutual aid groups, parent clubs, informal helping networks among relatives and/or neighbours) available to families.

Family support systems are particularly essential for three types of families with children: families with working mothers, families at risk, and families in crisis. Families with working mothers need two kinds of support: financial support to mothers and/or fathers during part or all of the first year after childbirth to assure normal parent-child contact during the earliest period of development; day care facilities (family day care homes, day care centres) for both preschool children and schoolchildren.

To prevent psychosocial problems and social deviance in children (including juvenile delinquency, suicide, etc.) it is vital that families at risk be identified and assisted. The most common risk variables associated with these problems are lower social class and poverty; other risk factors are large family size, substance abuse (including alcoholism), older children

with school failure or social deviance, etc. Priority should be given to families in the risk groups which are amenable to change, and measures should be envisaged which are both feasible and practical.

Families in crisis can include families in which: one parent is hospitalized, imprisoned or dies; parents separate or divorce; a child is found to have a chronic health condition; etc. The type of family support needed will, of course, vary according to the crisis. As an example, the support system for the family in which a child is found to have a chronic illness or handicap should include counselling for parents and child, special equipment or services (including home teachers) in the home when needed; and provision for the family to be temporarily relieved of the extra burdens of the child's affliction (day care, weekend care, holiday camps for the child).

4.4.2 *Services at school*[a]

Most young people of 5–18 years in the European Region spend the greater part of their waking hours in school, and schools therefore have a great impact on their overall development. Our perception of the role of the school in modern industrial society is beginning to change from that of an instrument to further economic development to that of an educational experience which will prepare young people for a meaningful life. In this regard the Conference stressed the right of all school-age children to continuous education, regardless of their economic, geographical or health circumstances.

The changing role of the school has made it necessary to re-evaluate the entire schooling process, including what is to be taught, how it is to be taught and the place of the school in society. It is clear that significant changes in policy will have to be made if schools are to fulfil their new role, and the Conference sought to emphasize several principles which it felt should underlie such changes. The first principle is the need to open up the school and integrate it more closely with the family and the community. While the school has always been, in theory, part of the community, its educational philosophy, curriculum and methodologies have often not kept pace with rapidly changing social conditions. An open-door policy for schools has many facets and ramifications, which include increased cooperation between teachers and parents, improved communication between the school child and the local community, and greater collaboration among health authorities, social authorities and educational authorities at the central and local level.

A second principle is the need for schools to have a more flexible approach to students as individuals. When a child has difficulty at school,

[a] School health services are not included here – see section 4.2.

the question "What is wrong with school?" must be asked as often as the question "What is wrong with the student?". While a balance between the degree to which a child should adjust to school and the degree to which the school should adjust to the child must be found, in the past the scales have tilted too often on the side of the former and rarely on the side of the latter. Greater emphasis should be placed on a child's developmental age rather than on his chronological age.

A third principle is the need for the school to recognize the vital role it plays in the process of socialization of the child and to identify and exploit its role in this process. Two examples will illustrate the role the school can play: school entry – part of normal socialization; school deviance – one form of abnormal socialization. Most of the problems of school entry[a] result from school policy which forces a sudden, major shift in the socialization process of the young child. Solutions to these problems, therefore, lie in changing school policy to allow for a more gradual transition in this process. Several solutions could be applied: gradually bringing the community into the child's life prior to school entry through such measures as local play groups, creating programmes to evaluate the child's preparedness for school and establishing more flexible admission policies geared to developmental age.

Problems of social deviance (juvenile delinquency, drug abuse, etc.) are highly complex, multifactorial, sometimes interlinked, and as yet poorly understood. This makes it difficult to know where to begin in dealing with such problems. For several reasons it appears that programmes for the prevention and treatment of social deviance should devote particular attention to the school. Research indicates that socially deviant children often come from families which are broken, poor, have low levels of education and in which there are other deviant members; it is thus unreasonable to expect that many of these families will be able to reorient or improve the socialization process of their children without assistance. In such cases, the school can have a compensatory function. While school personnel are often not yet prepared professionally for such tasks and do not usually see themselves involved in the lives of their pupils outside school, it would nevertheless seem preferable, as a first step, to train teachers rather than parents to work with deviance problems. In developing such programmes in the school, close cooperation between parents, school staff, school health personnel and social and legal institutions in the community is essential. School policies will also need to be altered. For example, since in many schools students over 12 years of age have a number of teachers, each teaching a specific subject, young persons at risk of or exhibiting social deviance could be assigned for regular periods to a teacher of their choice who could advise them and serve as a positive role model.

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[a] These are discussed in detail in the report on the Working Group on Problems of Children of School Age (5 – 9 years) (ICP/MCH 004).

A final principle is the need to recognize the two-way relationship between education and health and the striking correlation between the level of general education and health status. In this regard it must be stressed that health is too important to leave only in the hands of doctors, and education is too important to leave only in the hands of teachers; society in general, including parents and children, should play an active role in both.

With regard to the effects of education on the health of children and adolescents in school, several recommendations may be made. The physical health of students requires school policies to ensure regular physical training activities at school and a balance between physical and mental exercise. The mental health of students requires school policies which guard against the labelling of "bad" students and emphasize a qualitative appreciation of a child's behaviour, stressing the stronger and weaker points of his behaviour and suggesting remedial, rather than punitive, action for it. A school environment conducive to the health of students must be created. This effort, involving city planners, architects, educators, medical personnel, engineers, etc., must provide for: appropriate furniture, equipment, light, heating and space in the classroom; adequate and safe play areas; and an approach to accident prevention which takes into consideration not only dangers at school but also hazards children might encounter when travelling to and from school. The food programme at school should provide well-balanced, warm meals when children attend all day, be supervised by staff able to detect early signs of malnutrition so that children with conditions such as obesity can be helped, involve the children, family and community in food selection and preparation, and be an educational experience for students.

With regard to the effects of health on the education of children and adolescents, the management at school of the young person with chronic health deviance is of primary importance. The placement of such young people at school is a fundamental factor. Programmes which segregate children and adolescents who are physically or intellectually deviant need to be re-evaluated in the light of their psychological and social effects. Children with chronic health deviance (including chronic disease and handicaps) should be placed in an educational setting that is as close to normal as possible: in most cases in a normal school in normal classrooms and with normal teachers. This policy is advantageous both to the deviant child, who will often do better in the long run, and to the normal child, who learns to adapt to those with abnormalities and to appreciate the "normality of deviance" in the human group. The management of children with chronic health conditions also demands a multidisciplinary team approach at school and an integration of school programmes with those of the community.

The principles and policies presented above have many implications for teachers. It is well known that teachers endure excessive occupational stress resulting from excessively large classes, low prestige and salaries, and performance-oriented administrative policies (i.e., the teacher's competence

is judged by the academic performance of his pupils. The strain experienced by teachers must be reduced to allow them to make full use of their potential professional capacities to the benefit of their students. Teachers need time for contact with the families of their students and for consultation with the other members of the school team (psychologist, school health personnel, etc.). Methods are needed to improve both the basic and inservice training of teachers and the periodic re-evaluation of their work.

4.4.3 *Services in the community*

Services in the community for children and adolescents include social services, legal services, recreational programmes and services in the work setting. As with all other services, the key to the improvement of community services is integration. This must include integration of the community services themselves, integration of community services with services in the school and the family, and integration of children and adult services. Community services for children and adolescents are manifold, but the approaches needed to improve all of them may be illustrated by three examples: accident prevention programmes, vocational programmes and leisure programmes.

Accidents provide an excellent illustration not only of the nature of the present-day problems of children and adolescents, but also of the nature of the solutions: these solutions demand a community effort and involve a multidisciplinary effort (politics, engineering, city planning, architecture, psychology, sociology, education, health) in community planning. A systems approach shows that the possible solutions, though complex, may be narrowed down to four general factors: hazards in the environment, children at particular risk, supervision, and education. An assessment of the potential efficacy of three of these factors is discouraging: we are not yet able to identify young people at high risk; supervision may be important in pre-school children but it is not very relevant to school-age children; educational efforts have been extensive in the past and, although they have been helpful, they have had limited results. However, programmes focusing on the first factor, hazards, have shown the most promise for effective accident prevention and it is recommended that future programmes should place the emphasis here. An example of this approach is the reduction of road traffic hazards for children travelling to and from school by taking the following steps: locating schools away from main roads; providing school patrols at predetermined dangerous crossings; strictly enforcing speed limits near schools; placing fluorescent spots on outer garments; changing school hours so that opening and closing do not coincide with hours of heavy traffic. Such an approach is clearly a community effort involving all the parties mentioned above.

School leaving and work entry form another major step in the process of the socialization of young people and, as with school entry, should be

gradual and planned and should involve family, school and community. Vocational education programmes in the school, to assist in this process, should begin early, since children of 10–13 years have already begun to concern themselves with the choice of their career and work. The aim of these programmes should be to prepare the young person for satisfying work, not just to find him or her a job. The family still has an over-riding influence on the career choice of children and the school must work closely with families, both in developing objectives for vocational education programmes and in counselling individual students. The school must also work closely with industry to ensure that the objectives of the programme and the advice given to students are realistic and correspond to local community employment opportunities and career needs.

Vocational education programmes in the school should provide continuous career guidance throughout the pre-teen and teenage years and should include assessment and counselling of individual students. In order to improve vocational suitability, assessment should include physical, intellectual and psychosocial abilities and weaknesses, vocational aptitude and interests. After an assessment has been made, counselling will include helping the student to identify his own abilities, aptitudes and interests and informing him of the job market situation and the social conditions associated with various vocations. Armed with such information, students will then be better able to make rational and intelligent choices with regard to their future careers. The counselling of young men and women should include the provision of information on parenthood as a temporary career, with the option of a more permanent career in a child care profession or elsewhere. These programmes of assessment and counselling are greatly facilitated by arranging employment for young people, while still at school, in economically and vocationally meaningful activities in the local community. This brings the school into the community and is of great value not only to the individual student but also to school guidance personnel.

Vocational programmes for young people should also be available in the job setting. Industry needs to assess and counsel new young recruits to ensure the job placement that is most suitable, both for the employer and for the new young employee. Those in charge of such programmes should include occupational physicians who specialize in adolescence and who work closely with the schools. This brings industry to the school and benefits not only young workers but also industrial management and occupational health personnel who learn more about the characteristics, needs and problems of their adolescent recruits.

Because premature school leaving, unemployment and inappropriate employment are widespread among young people in many industrialized societies and are factors which greatly affect their social development, programmes are urgently needed to create more meaningful jobs or other activities for those in one of these situations. Young persons in this high-risk category

can benefit greatly from various support systems, especially those involving peer groups, as well as from opportunities to work in services where person-to-person contact is a predominant feature.

Programmes of leisure activities are an important and often neglected part of community services for children and adolescents. The process of socialization includes the need to develop personally satisfying, socially appropriate leisure activities. The choice and pursuit of leisure activities in childhood lay the foundation for these pursuits throughout adult life. Such activities should be recreational and must include possibilities for physical activity, rest and contemplation, personal initiative, social interaction, culture and aesthetics. They should also include the opportunity to choose socially meaningful activities (shopping for elderly or handicapped neighbours, etc.). While some changes in the lives of children and adolescents, brought about by industrialization, increase the need for and importance of leisure activies – prolonged schooling, shorter working hours, more time spent outside the family and the school – other recent changes in society have reduced the scope of leisure possibilities – urbanization means less opportunity to explore or restructure the environment.

For these reasons community services for children and adolescents should include a "leisure activities section". The services will vary in organizational structure depending on the organization of community services: in countries with an existing extrafamilial support system for young people, leisure activities can be incorporated in this system, while in countries without such a system, leisure activities must be included in the general family support system. Regardless of their organizational structures, leisure programmes for children and adolescents should meet four basic criteria: adequate space should be provided; a variety of activities should be offered; participation should be on a voluntary basis; and young people should be actively involved in the planning and implementation of the programme. In addition, consideration should be given to the development of special leisure programmes for children and adolescents with special problems (alcoholics, drug addicts, the physically handicapped, etc.). The possibilities for specific leisure activities are many and varied, and each has its own particular advantages. Examples include: school clubs, youth organizations, summer or holiday camps, sports clubs, children's libraries and children's theatres, free play areas with building materials and other items provided. In addition to providing these more highly organized group leisure activities, planners should also consider ways of extending the leisure activities of individual children in ways which will facilitate physical and psychosocial development.

4.5 Manpower training

If the new problems of children and adolescents in society are to be understood and innovative services are to be appropriately staffed, changes

in manpower training are essential. The training programmes for all those working with children and youth – teachers, social workers, doctors, nurses, etc. – must be re-evaluated in the light of our new knowledge of the problems and their solutions. In this re-evaluation a number of recommendations should be borne in mind; these will be briefly reviewed here.

The first recommendation is that the team approach be taught to all those who work with young people. This involves learning how to share responsibility and respecting the expertise and competence of others.

A second recommendation is that the principles, approaches and practices of modern sociology and social psychology be taught both during the basic training and the continuing education of all those working with children and youth. As well as covering the psychosocial characteristics of children and families, such training should also include instruction on how to listen, how to interview and how to relate to and work with children and families.

Another recommendation is that the normal characteristics and common deviations (physical and psychosocial) of children and adolescents be taught to all those who work with them and to the parents and young people themselves. This involves, on the part of the various disciplines, considerable sharing of "professional" knowledge with each other and with the general public. The importance of doing this has been illustrated repeatedly in this report.

The strengthening of both the basic and the inservice training of teachers in health is a further recommendation. This must include preparing teachers for the teaching of sexuality, living together and parenthood. The training of teachers in these subjects will necessarily include a self-evaluation by the teacher of his or her own attitudes and practices with regard to health and sexuality. This is imperative because teachers must be at ease with the subject-matter and with themselves, and recognize the importance of their function as "models" in the classroom.

The final recommendation concerns the methods of teaching to be used when training those who work or will work with young people. In general, lectures are less effective than "teaching-learning" techniques such as informal discussions and group sessions. In addition to theory in the classroom, it is important to have practical experience, i.e., training in real-life situations. Whenever possible, the training should be multidisciplinary, including instructors and students from appropriate disciplines. Training in how to work with children and young people should be continuous and life-long, beginning in the school itself and proceeding through undergraduate, graduate and inservice education.

5. CONCLUSIONS AND RECOMMENDATIONS

1. While the Conference limited its deliberations to the consideration of children of school age (5–18 years), it recognized the importance of fetal and early child development to health during subsequent stages of life, including later childhood and adolescence. It therefore recommended that authorities responsible for school-age children and adolescents should integrate services for them with the services provided during the antenatal, perinatal, infant and preschool periods of life.

2. The Conference stressed that growth and development are separate concepts and that desynchronization of these two processes is the main cause of many age-specific problems. It recommended that, in the formulation of standards of growth and development and in the assessment of individual developmental status, asynchronous development as well as acceleration and retardation be included in risk factors; that normal growth and development by used as a positive index of health status if "normal" is understood to mean "average" and not necessarily "optimal"; that biological, sexual, psychological and social parameters be included; that measures of biological and psychosocial functional abilities such as physical fitness and adaptation to society be included; that children be screened at key periods of life, such as school entry and puberty; that the search for better methods of assessment (biological, sexual, psychosocial), including simpler methods which can be administered by nonphysicians, be continued; that children, parents and teachers be involved in these assessment programmes and that the principles of growth and development be taught to children and to all those who work with them.

3. The urgent need for more information on the newer morbidities of children and young people in more developed areas was reiterated. In this regard, the increasing prevalence of chronic conditions and handicaps (physical, psychological and social) was recognized, as well as the desirability of placing children and young people with such chronic problems in normal psychological and social environments as far as possible. Hospitals for such persons should be normalized so that stays are as short as possible, placement is determined by normal needs (peer relationships, etc.) rather than by special needs (disease category), and educational, social and leisure services are provided. Wherever feasible, such children and young people should be placed in normal schools, which should receive the necessary support (special teacher training, smaller classes, multidisciplinary teams, etc.).

4. The Conference recognized the importance of the socialization process in children and adolescents and the varying degree of influence of family, school, peers and community on this process at different ages. Although

the family is changing profoundly in modern society it continues to play a central role in this process. The increasing tendency in most countries of the Region for women to remain gainfully employed after childbirth cannot be viewed negatively, since it is conducive to the increased self-expression and personal development of the mother, a widening of the father's role, and an improvement in the family's economic situation. Families with working mothers need community support, including day-care centres and paid maternity and paternity leave. The role of the school in the socialization process has to be explicitly identified and widened to produce long-term effects. Community activities outside the home and school which aid the socialization of children and adolescents (cultural, sporting, political, recreational, etc.) should be organized to ensure that families and the children themselves participate as fully as possible in both planning and implementation.

5. Since faulty socialization (social deviance) is a fundamental cause of many of the more serious problems of children and young people today (substance abuse, accidents, suicides) more research is urgently needed on social deviance and more preventive and remedial action should be taken. Such programmes should devote special attention to families at risk and should involve schoolteachers and other personnel who work with children and adolescents.

6. The rapidly changing nutritional patterns of industrialized societies produce new problems which, in turn, require new approaches. Overnutrition (obesity) has replaced undernutrition as the new form of malnutrition and this problem, caused by a complex of biological, psychosocial, environmental and cultural factors, needs more research. The quality of food provided in collective feeding arrangements for children and young people (school canteens, etc.) is another area that deserves particular attention.

7. The Conference recognized the two-way relationship between health and education and the close link between the level of general education and the level of health. It stressed the right of all children of school age to receive uninterrupted education regardless of their economic, geographical or health circumstances. The role of the school in modern society needs to be reassessed. This reassessment should include: finding ways to enhance the role the school plays in the local community by establishing closer relationships between children, teachers, parents and community members; finding ways to decrease the occupational stress of schoolteachers brought about by oversized classes, low prestige and salaries and performance-oriented administrative policies; identifying teaching methods conducive to better health, such as the qualitative appreciation of behaviour rather than merely labelling it "good" or "bad"; improving both the basic and the inservice training of teachers in health and the methods for periodic re-evaluation of teachers.

8. Innovative techniques in the health education of children and young people are essential if it is to become really effective. Such innovations should: aim to improve the abilities of the child to use his own resources for his own health care by imparting the truth about health and health risks, teaching skills in identifying symptoms of ill health and tactics to deal with them, including how to think in epidemiological terms; stress positive rather than negative values; teach the concept of community health by providing pupils with knowledge, skills, and opportunities to tackle public health problems in their own community and by creating policies which strengthen community networks linked with the school. In developing innovative approaches to health education there is a need for more study of forms of influence on young persons which may prove effective in health promotion programmes (use of mass media, participation of actors, sports champions, well-known personalities, etc.).

9. The Conference considered at length the urgent need to improve educational programmes for children and adolescents in sexuality, living together and parenthood. This need, accentuated by the accelerated sexual development of young people in industrialized society, is based not only on the negative aspects of this problem (increase in the number of unwanted adolescent pregnancies and cases of sexually transmitted disease) but also on the positive benefits of preparation for a satisfying, socially integrated personality and a happy life with a partner. It was agreed that these educational programmes should: be a continuous health promotional activity starting in the family with young children and continuing throughout the school years; include medical personnel to train teachers and counsel youth; be made compulsory in schools by encouraging governments to use and enforce legal mandates and develop undergraduate and inservice training of teachers in this subject.

10. The Conference stressed the importance of vocational education programmes for young people, including the possibility of engaging children, while still at school, in economically meaningful activities in industry in the local community. Because unemployment and inappropriate employment are important factors affecting the social development of youth in industrial societies, the Conference also recommended programmes aimed at increasing meaningful job opportunities for young people, especially school dropouts.

11. Because the needs of children and adolescents in the more developed areas are not being met by traditional maternal and child health programmes, the Conference endorsed the concept of primary health care as the most suitable approach in this connexion. This approach presupposes the multidisciplinary participation of various sectors of society (health, education, social welfare, industry, etc.) as well as of families and children themselves

in the planning and provision of primary level services. Not enough is known about services for children and young people and the Conference recommended the development of health service research in this field. Enough is known today, however, about the problems of children and youth and the more promising solutions to them; hence the Conference strongly recommended changing present services now while awaiting future research results. The innovative changes recommended in existing services are numerous and the Conference stressed the importance of less traditional social and health programmes which involve young people to the greatest extent possible in the planning and management of services. It expressed the conviction that these innovative services could be funded if: outdated activities which no longer meet present needs are abolished; the favourable cost-benefit ratios of many of the proposed preventive activities are highlighted; the first innovations selected are among the many which do not call for substantial additional funds; the International Year of the Child was regarded as an opportune time for planning and financing new activities in the field of child health.

12. There is a need for changes in professional training if the more recent problems of children and young people are to be understood and innovative services are to be appropriately staffed. This professional training should include the following: a review of present curricula of basic training for all those working with children and adolescents in the light of the existing knowledge of new problems; the principles, approaches and practices of modern sociology and social psychology during both the basic training and the continuing education of all those working with children and youth; multidisciplinary team seminars.

13. Services should accentuate the clearly dominant, positive (normal, healthy) aspects of childhood and youth. The basically morbidity-oriented approach to child health assessment should be gradually replaced by positive health indices. Health education programmes which focus on dangers, diseases and "don'ts" should be replaced by positive encouragement of self-directed behaviour which leads, for example, to satisfying occupations, fulfilling physical activities in sports and leisure, and happiness in sexual and family life. Health services which focus on the abnormality of the sick child (for example, hospitals for specific diseases) should be replaced by health services which focus on the normal needs of the sick child, which predominate in all cases except, perhaps, terminal illness, and on the integration of that child in the family, school and community.

Annex I

LIST OF RELATED WHO PUBLICATIONS

WHO Regional Office for Europe

ICP/HRP 004	*New trends in maternal and child health:* report on a Conference (Moscow, 1974) 1975
ICP/MCH 004	*Problems of children of school age (5–9 years):* report on a Working Group (Copenhagen, 1975) 1976
EURO 5425 III	*Problems of deviant social behaviour and delinquency in adolescents and young adults:* report on a Working Group (Helsinki, 1972) 1973
EURO 5437 IV	*Existing patterns of services for alcoholism and drug dependence:* report on a Study, 1973
EURO 5430 III	*Major issues in juvenile delinquency:* report on a Symposium (Bratislava, 1973) 1974
ICP/MNH 015 III	*Suicide and attempted suicide in young people:* report on a Conference (Luxembourg, 1974) 1976
ICP/MNH 016 (1) III	*Youth advisory services:* report on a Working Group (Lübeck, 1975) 1976
ICP/CAN 002	*Child cancer control:* report on a Working Group (Prague, 1977) 1978
ICP/MCH 008	*Immunization programmes for children:* report on a Working Group (Copenhagen, 1976) 1977
ICP/MCH 006	*Problems of children of school age (10–13 years):* report on a Working Group (Moscow, 1976) 1977
ICP/MCH 010	*Problems of children of school age (14–18 years):* report on a Working Group (Amsterdam, 1977) 1978

ICP/MCH 017	*Service-oriented research in adolescent fertility:* report on a Meeting (Warnemünde, 1978) 1979
ICP/MNH 016 III	*Patterns of youth advisory services:* report on a Study, 1977
ICP/MNH 035 III	*Objectives of youth advisory services:* report on a Working Group (London, 1977) 1979
ICP/NUT 003	*The role of nutrition in public health:* report on a Working Group (Algiers, 1976) 1978
ICP/MCH 007	*Evaluation of school health programmes:* report on a Working Group (Bucharest, 1977) 1978
ICP/BVD 003	*The surveillance and control of sexually transmitted diseases:* report on a Symposium (Vienna, 1976) 1977

WHO Headquarters

Technical Report Series, No. 583	*Pregnancy and abortion in adolescence:* report of a WHO Meeting (Geneva, 1974) 1975
Technical Report Series, No. 600	*New trends and approaches in the delivery of maternal and child care in health services:* Sixth Report of the WHO Expert Committee on Maternal and Child Health, 1976
Technical Report Series, No. 609	*Health needs of adolescents:* Report of a WHO Expert Committee, 1977
Technical Report Series, No. 613	*Child mental health and psychosocial development:* Report of a WHO Expert Committee, 1977
Public Health Papers, No. 58	*Suicide and attempted suicide* (Part I: Ascertainment of deaths from suicide, by E.M. Brooke & M. Atkinson; Part II: Suicide and attempted suicide in young people: report of a Working Group (Zagreb, 1973)) 1974

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